June 2007

Evaluation Design of the New Hampshire Cancer Control Plan

Revised Evaluation Plan

Prepared for

Margaret Murphy
Section Administrator
New Hampshire Department of Health and Human Services
Division of Public Health Services
Comprehensive Cancer Control and Prevention

Prepared by

Brenda Stone-Wiggins
Debra Holden
RTI International
3040 Cornwallis Road
Research Triangle Park, NC 27709

RTI Project Number 0210372.000

RTI Project Number
0210372.000

Evaluation Design of the New Hampshire Cancer Control Plan

Revised Evaluation Plan

June 2007

Prepared for

Margaret Murphy
Section Administrator
New Hampshire Department of Health and Human Services
Division of Public Health Services
Comprehensive Cancer Control and Prevention

Prepared by

Brenda Stone-Wiggins
Debra Holden
RTI International
3040 Cornwallis Road
Research Triangle Park, NC 27709

Contents

Exhibits

1. INTRODUCTION

Comprehensive Cancer Control, as defined by the Centers for Disease Control and Prevention's (CDC's) Division of Cancer Prevention and Control (DCPC), is "an integrated and coordinated approach to reducing cancer incidence, morbidity, and mortality through prevention (primary prevention), early detection (secondary prevention), treatment, rehabilitation, and palliation" (Abed et al., 2000, p. 68). To advance the CCC approach, in 1998, CDC initiated a national program to provide resources to states and tribal communities to develop an action plan that uniquely addresses their cancer burden. With a 2003 planning grant from CDC, New Hampshire began a 2-year collaborative planning process that resulted in a 5-year cancer control plan: *Cancer in New Hampshire: A Call to Action 2010* (New Hampshire Comprehensive Cancer Collaboration [NHCCC], 2005). In September 2006, the New Hampshire Department of Health and Human Services (NHDHHS), on behalf of NHCCC, contracted with RTI International (RTI) to design a 5-year plan to evaluate the implementation of its comprehensive cancer control plan.

The Plan provides a comprehensive, detailed strategic approach for reducing the burden of cancer in New Hampshire by focusing on breast, colon, lung, prostate, and skin cancers. More than half of New Hampshire's cancer deaths are attributed to the first four cancers (NHCCC, 2005, p. 7). In addition to being the most common cancers, these five cancers were also selected because of the potential to intervene and to "substantially reduce" New Hampshire's cancer burden. *A Call to Action 2010* contains 91 strategies organized around five goals that follow the cancer continuum: primary prevention, prevention and early detection, treatment and survivorship, palliation, and emerging issues. Within each goal, these strategies are further organized under 17 priority objectives. The Plan also identifies three issues that are relevant to addressing cancer morbidity and mortality in New Hampshire: (1) its increasing ethnic and racial diversity, (2) the geographic disparity experienced by its rural residents, and (3) its aging population.

Developing the Plan was a collaborative effort among more than 100 partner organizations and individuals (including cancer survivors). The planning process was guided by the NHCCC Steering Committee, a core group of 26 individuals representing 14 organizations (Exhibit 1-1). Four of the 14 organizations had multiple representatives. The membership consisted of the public, nonprofit, and private sectors; national, state, and local organizations; diverse professionals (e.g., oncologists, surgeons, epidemiologist, communication specialist, patient advocates, public health practitioners); and every geographic region of the state. Initially, the Steering Committee, later renamed the Board of Directors, created workgroups around the targeted cancers but later changed the structure to correspond to the five goals (i.e., primary prevention, prevention and early detection, treatment and survivorship, palliation, and emerging issues). They also added a Data Workgroup. A majority of the current Board (19 or 73%) was involved in development of the Plan, ensuring continuity into the

Exhibit 1-1. Partner Organizations Represented on the New Hampshire Comprehensive Cancer Collaboration Board of Directors, 2003–2006

Partner Organization	Number of Representatives
New Hampshire Department of Health and Human Services	7
American Cancer Society	4
City of Manchester Health Department	3
Concord Hospital	2
Concord Surgical Associates[a]	1
Dartmouth-Hitchcock Medical School	1
Dover Surgical Associates[a]	1
Elliott Hospital	1
Foundation for Healthy Communities	1
New Hampshire State Cancer Registry	1
New Hampshire Hospice and Palliative Care Organization	1
National Cancer Institute's Cancer Information Service	1
St. Joseph Hospital	1
The Leukemia and Lymphoma Society	1

[a]Former and Current State Chairs, American College of Surgeons.

implementation phase. For example, 9 of the 11 Workgroup Chairs and Co-Chairs, who are charged with implementing the Plan, were on the original Board. It is the Board's priority to ensure that *A Call to Action 2010* is "not simply a report on cancer, but function[s] as a clearly defined action plan" (NHCCC, 2005, p. 4).

Evaluation planning was seen as an important antecedent to implementation of *A Call to Action 2010*. As a result, the Board contracted with RTI to systematically create a comprehensive evaluation plan for *A Call to Action 2010* that will be used by the NHCCC Board to better direct coordination and integration among the partner organizations, inform overall program improvement, and assess accomplishments by the New Hampshire cancer control partners in implementing the priority strategies. NHCCC established the following performance measures for the work to be completed under this contract:

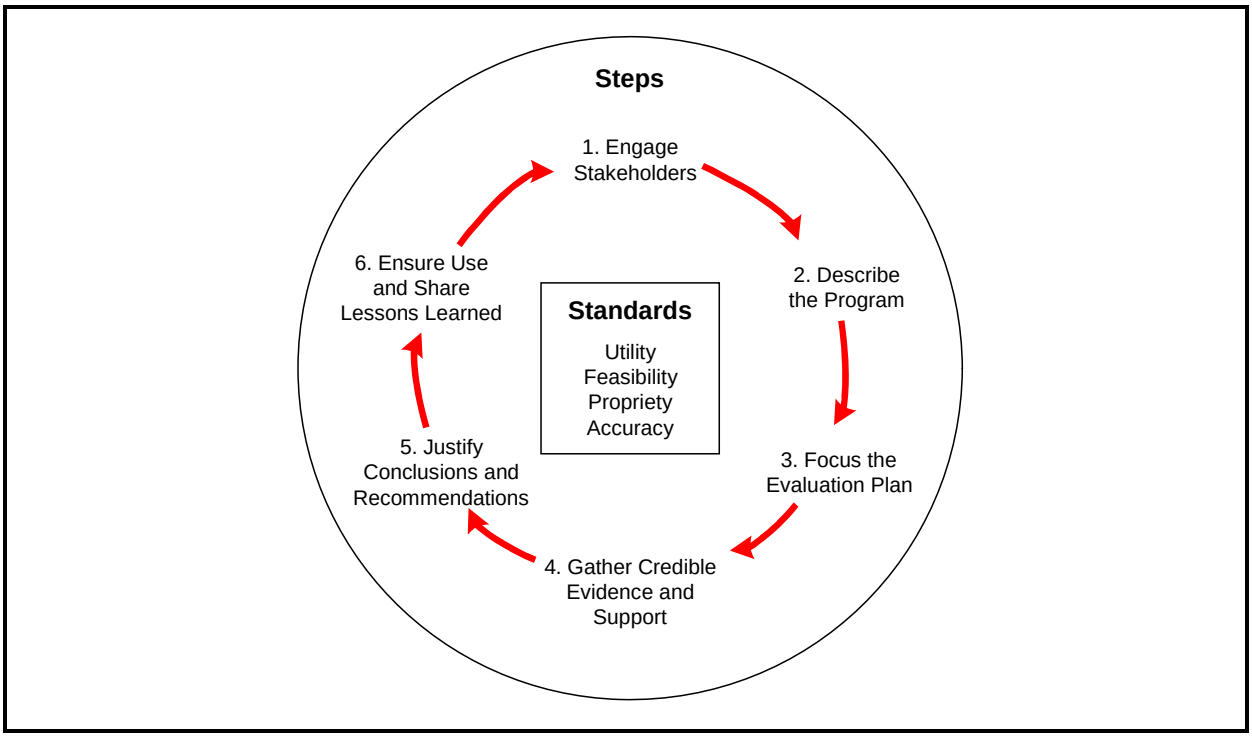
- evaluation criteria for implementation of the cancer control plan
- evaluation tools for implementation of the cancer control plan
- logic model for evaluation of the implementation phase of the cancer control plan
- pilot testing and written report of the pilot testing
- written evaluation plan

Section 2 details the six evaluation planning steps that RTI followed to complete the plan.

2. EVALUATION PLANNING APPROACH

RTI followed CDC's "Framework for Program Evaluation in Public Health" (1999) to guide the evaluation planning process (Exhibit 2-1). The six steps are (1) *engage stakeholders* to gain their input throughout the planning process (Section 2.1); (2) *describe the program* (Section 2.2), which can include document review, stakeholder interviews, and development of a logic model/conceptual framework; and development of an evaluation planning matrix (EPM) and inventory of data sources to (3) *focus the evaluation plan* (Section 2.3). The last three steps—*gather credible evidence and support* (Section 2.4), *justify conclusions and recommendations* (Section 2.5), and *ensure use and share lessons learned* (Section 2.6)—relate to implementation of the evaluation plan. At the heart of the framework is a set of standards for assessing the quality of evaluation activities: utility, feasibility, propriety, and accuracy. In each section, we provide an overview of how this step-by-step approach resulted in the NHCCC Evaluation Plan—the process, the products created from the process, and relevant evaluation planning principles. In Section 2.1, we define the stakeholders, describe their role in developing the plan, and describe how RTI engaged them in the process.

Exhibit 2-1. CDC's Framework for Program Evaluation—Adapted Steps for New Hampshire Comprehensive Cancer Control Evaluation Plan Development

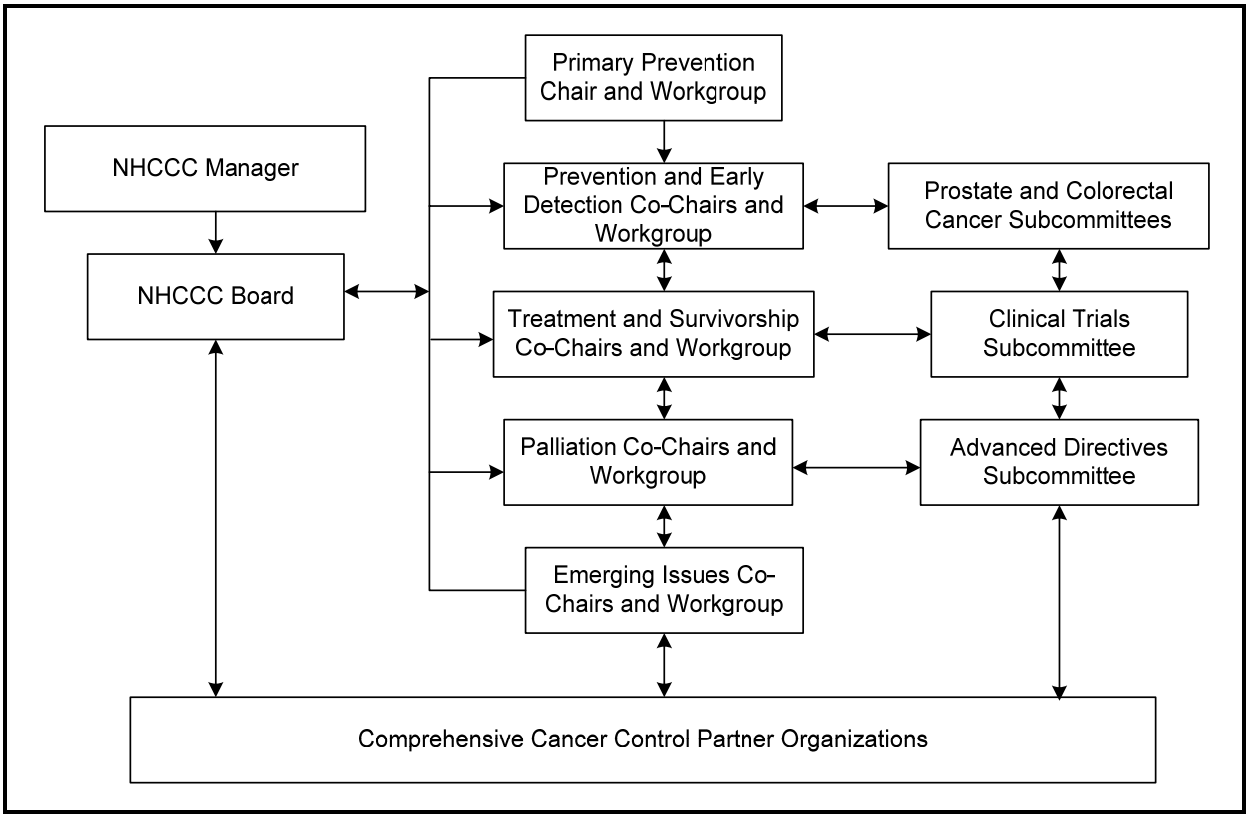


Source: Centers for Disease Control and Prevention (CDC). 1999. "Framework for Program Evaluation in Public Health." *Morbidity and Mortality Weekly Report* 48(RR11):1-40.

2.1 Engage Stakeholders (Step 1)

Key stakeholders are defined as those individuals who have a "stake" in the program under study and/or the evaluation findings (Patton, 2002). For this project, stakeholders included the individuals involved in overseeing, managing, and ensuring the implementation of the Plan: specifically, the 19-member Board, 11 Workgroup Chairs and Co-Chairs, the NHCCC Board Manager, the NHDHHS Project Director, and the partner organizations (Exhibit 2-2). All of the Workgroup Chairs and Co-Chairs are members of the Board. In some cases, the same individual serves multiple roles. For example, the Board Chair is also Co-Chair of the Prevention and Early Detection Workgroup and Chair of the Colorectal Cancer Subcommittee. The majority of these individuals were part of the "coordinated alliance of stakeholders" that participated in developing the plan. They are generally experts in their content area, know NHCCC's priorities, and understand the cancer control challenges that could affect implementation of the plan. Therefore, it was essential to engage and involve them at all levels of the evaluation planning process.

Exhibit 2-2. NHCCC Network



RTI followed a systematic process for engaging stakeholders in the planning process. At the project kickoff, RTI initiated the evaluation planning process with a face-to-face meeting with the Board, the NHCCC Board Manager, and the NHDHHS Project Director. The purpose

of the meeting was to review the goals of the evaluation planning process, answer questions about RTI's approach to evaluation planning, solicit the Board's view of how the process would work, and collect relevant documents for review. For efficiency reasons, the 11 Workgroup Chairs and Co-Chairs were selected as the primary stakeholders to be involved throughout the evaluation planning. Later in the planning process, the Workgroup Chairs and Co-Chairs reviewed and provided feedback on drafts of the logic models (Section 2.2), EPM (Section 2.3), and documents on the design of the Strategy Implementation Tracking Tool (Section 2.4). RTI revised the documents to incorporate stakeholder input and to finalize the documents.

2.2 Describe the Program (Logic Models) (Step 2)

As described in Section 2, the second step in the evaluation process is to describe the program that will be evaluated. In this section, we provide an overview of the processes that we followed to describe the program and the products that resulted from that process: reviewing relevant documents, interviewing program staff, and developing a conceptual framework.

2.2.1 Document Review

The RTI team reviewed several NHCCC documents related to the implementation phase: *A Call to Action 2010*, Workgroups' work plans, the Board's top priorities for the C-Change budgeting process, and the report of interviews with the Board. In exploring potential funding through C-Change to implement the plan, the Workgroup Chairs had identified the top strategies on which to focus their implementation effort. In fall 2006, the NHCCC Board Manager also interviewed Board members (n=17) to gain their perspective on implementing the Plan (e.g., setting priorities, defining the individual and collective roles of the Workgroups and Board, identifying perceived strengths and challenges related to plan implementation). From our review of these documents, we learned that the strategies were further categorized into seven program focus areas: advocacy, assessment, disparate populations, public education/awareness, paid media campaign, provider education and support, and surveillance and monitoring (Exhibit 2-3).

Exhibit 2-3. Top 41 Priority Strategies by Program Focus

	Advocacy	Assessment	Disparate Populations	Public Education and Awareness	Paid Media Campaign	Provider Education and Support	Surveillance and Monitoring	Total
Primary Prevention	3	0	0	4	2	2	4	15
Prevention and Early Detection	1	1	0	4	1	2	6	15
Treatment and Survivorship	0	3	0	1	0	1	0	5
Palliation	0	0	0	0	0	3	1	4
Emerging Issues	0	1	1	0	0	0	0	2
Total	4	5	1	9	3	8	11	41

Identifying specific program components is an attempt to identify optimal strategies in terms of "relevance, efficacy, and cost-effectiveness" (Abed et al., 2000, p. 71). In other words, evidence-based strategies such as paid media and policy change are likely to be more effective (i.e., reach and intensity). On the other hand, strategies that raise awareness such as distributing brochures at a community festival may be easier to implement but less effective. Of the seven program focus areas, surveillance and monitoring seems to be the high priority program component.

The reality is that the plan lays out what should be done. Implementing the plan is driven by program capacity (i.e., existing resources), and it requires that NHCCC determine what is feasible (Abed et al., 2000). We learned that the Workgroup Chairs and Co-Chairs had already clearly defined only 41 of the 91 strategies as top priority and would focus resources and efforts on implementing them (Exhibit 2-4). As a result of their priority setting process, the majority of the 41 priority strategies (30 or 73%) focus on primary and secondary prevention. Information gathered through document review and interviews with program staff provided the foundation for conceptualizing how the program is expected to work.

Exhibit 2-4. New Hampshire Comprehensive Cancer Control Plan Components

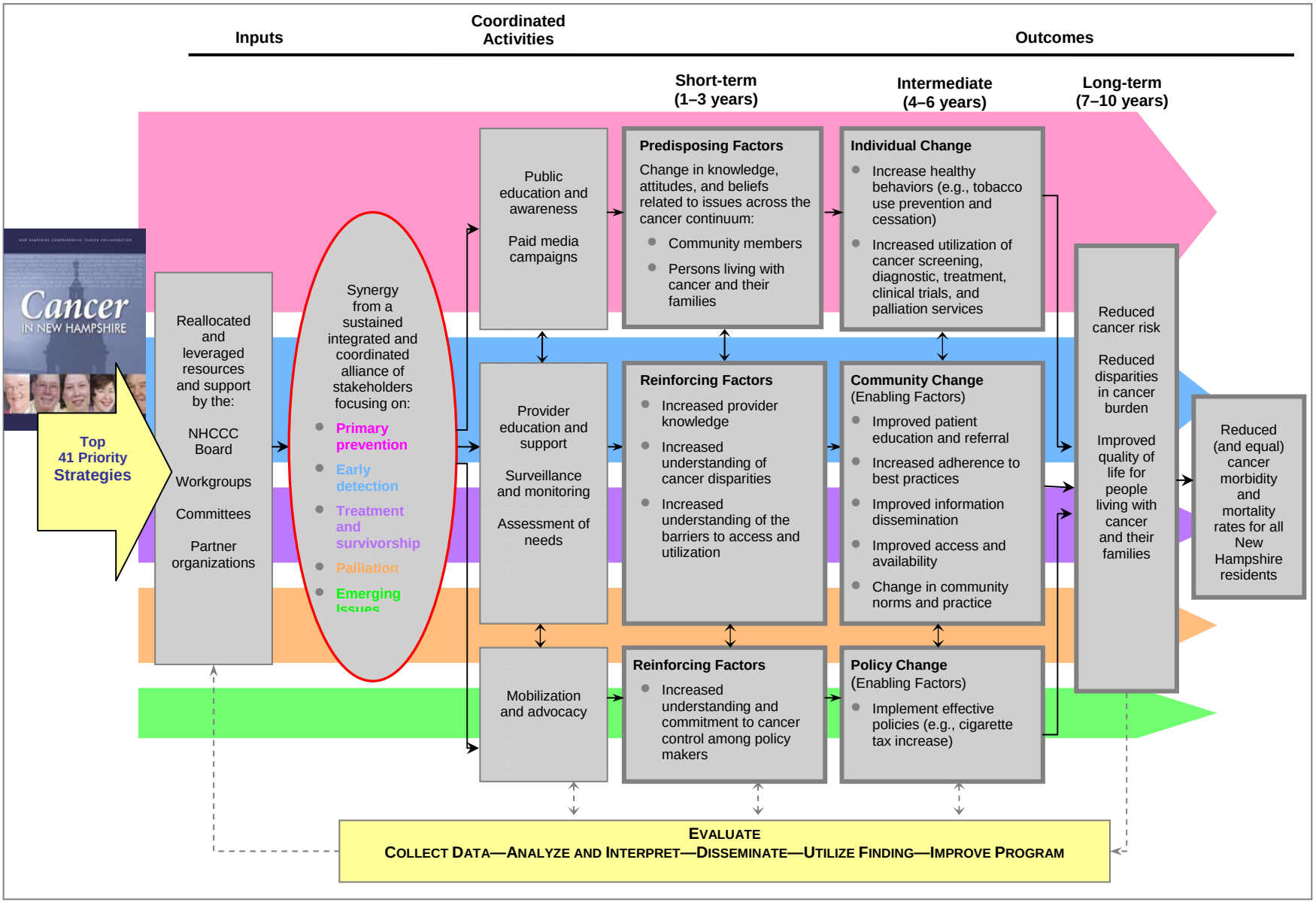
	Goal Number	Number of Priority Objectives	Number of Strategies	Number of Top Priority
Primary Prevention	1	6	28	15
Prevention and Early Detection	2	4	27	15
Treatment and Survivorship	3	3	12	5
Palliation	4	2	12	4
Emerging Issues	5	1	6	2
Total		16	91	41

2.2.2 Conceptual Framework and Logic Models

A conceptual framework is a tool that visually depicts in a logical sequence how the resources invested by New Hampshire (inputs) will lead to program improvements and, ultimately, to the desired distal population-level change. The framework is generally more theoretically based and conceptual than a logic model. A key advantage of a conceptual framework, in the context of a comprehensive, multilevel program such as NHCCC, is that it identifies the proposed interrelationships across major program components and activities (e.g., capacity building, partnership, collaboration development) and the expected relationship between these components and program outcomes. The Workgroup Chairs and NHDHHS Project Director recommended developing an overarching conceptual framework for NHCCC as well as logic models for each of the five program components. The logic models are presented in Appendix A. The resulting conceptual framework is presented in Exhibit 2-5 and described below.

The conceptual framework provides a big picture view of how NHCCC is proposed to work. It shows the relationship between its four major program components: the Program *Inputs* or foundation that the local initiatives will draw from; the *Synergy* from the partners' collective effort that is expected to exceed their individual accomplishment; the primary *Coordinated Activities* that the Program envisioned; and the desired short-term, intermediate, long-term, and ultimate *Outcomes*. Moving from the left to the right, the Framework provides a logical sequence of how the resources invested by the NHCCC Board, Workgroups, Committees, and partner organizations will lead to program improvements and the desired results. The main components of the conceptual framework—inputs, coordinated activities, and outcomes—are described in detail in the following sections.

Exhibit 2-5. Draft Conceptual Framework for the New Hampshire Comprehensive Cancer Control Program



Note: Refer to the logic model for each of the five program components.

Inputs

The primary inputs for the NHCCC program consist of the existing and leveraged resources of the Board, its Workgroups, Committees, and partner organizations. This infrastructure will direct and facilitate implementation of the strategies in *A Call to Action 2010*. NHCCC partners include partner organizations that are members of the Board and the Workgroups. They include representatives from local hospitals, provider organizations, advocacy groups, government entities such as the local health department, and policy makers. These partners will focus on building relationships across the various sectors of the community, assessing needs, identifying the gaps in services and polices that impact cancer disparities, and helping to leverage resources to address cancer disparities. To accomplish its goals, the following assumptions were made about how the Board will implement the plan:

- Cancer control partners will integrate and coordinate their efforts to create a greater impact of collective action (i.e., synergy).
- The Board and its partner organizations will reallocate existing resources to implement the 41 priority strategies.
- The Board will bring together new partnerships that will result in new opportunities and resources.
- The Board will identify new funding to address the gaps.

Program inputs are hypothesized to result in a synergy of effort by the partner organizations (depicted as an oval in the NHCCC conceptual framework [see Exhibit 2-5]). This synergy is expected to influence the focus, intensity, and reach of the activities implemented by the Board in the various New Hampshire communities. Lasker and Weiss (2003) define synergy as, "the breakthrough in thinking and action that are produced when a collaborative process successfully combines the complementary knowledge, skills, and resources of a group of participants" (p. 25). Establishing these partnerships is the beginning of the process. However, maintaining the relationships will be critical and will need to be supported by ongoing efforts to nurture the relationships, to ensure "buy in" from all essential partners, and to assess how well the partnership is functioning. In evaluating these partnerships, it is important to be aware that they develop over time, to assess how they function over time, and to be sensitive to how the process and structure (i.e., formalized rules and processes) can facilitate or hinder collaboration. According to coalition literature (Butterfoss and Kegler, 2002), synergy that flows from a partnership functioning is hypothesized to be a mediating factor in the causal pathway to performance (effectiveness).

Several factors will likely influence how well the Board collaborates to implement effective interventions and initiatives. First, it is essential to have broad and deep representation from the disparate community, such that local community leaders, the agencies they represent, and their peers and families are involved. For example, Hays et al. (2000) demonstrated that a partnership's ability to change policy was positively related to having broad sector representation. Serving as an advocate for the partnership and community, the

Board member plays a critical role in community organizing across diverse sectors and between organizations ("boundary spanner") by breaking down the boundaries that separate these nontraditional partners (McLeroy et al., 1988; Brinkerhoff, 2002). Second, it will be necessary to leverage additional resources. For example, paid media campaigns are expensive and execution will not happen without additional resources. A major responsibility of the Board is to ensure the engagement of a broad and representative group of participants in this effort and sufficient resources.

In evaluating this component of the program, potential evaluation questions could include the following:

- Who is participating (e.g., organizations represented, roles, responsibilities, attendance)?
- What sectors of the community are not involved but should be?
- What are the local community contextual factors that could impact how well the Board can function?
- What resources are available to the NHCCC Program (e.g., Board, Workgroups, staff, funds, partner organizations)?

Coordinated Activities

"Coordinated activities," the second column in the conceptual framework (see Exhibit 2-5), relates to the actions the Board and partner organizations will take to address cancer-related disparities. All of the strategies in the plan have been categorized by the Workgroup Chair and Co-Chairs into eight program focus areas. In their effort to effect change, and ultimately reduce cancer incidence and mortality, the Board has defined strategies (and the attendant activities) at three socio-ecological levels: individual, community, and policy:

- Individual-level change depicts the attitudes, beliefs, perceptions, and behaviors of the residents targeted by interventions (e.g., the relationship between screening behaviors and attitudes). At this level of change, as depicted in the NHCCC conceptual framework, NHCCC will conduct public education and awareness activities as well as paid media campaigns.
- Community-level change emphasizes the significance of system-wide change in influencing the health behaviors of individuals. Examples of community-level changes relevant to NHCCC include whether organizations within the community work together more effectively to address cancer care or to influence community norms. As a result, the community supports the individuals in their effort to change to cancer prevention behaviors or to avoid cancer risk. This level of change is referred to in Exhibit 2-5 and includes activities that focus on the following three program areas:
  - provider education and support
  - surveillance and monitoring
  - assessment of needs
- The third level is mobilization of the community and advocacy. It includes policy changes such as increases in cigarette tax and local agencies working together to

ensure mammography screening services for low-income, uninsured women. Or, the change could be program eligibility requirements to allow for more people in the community to be served through the breast cancer early detection screening program. Overall, the socio-ecological model provides a framework for examining the focus of the activities to determine their broadness and comprehensiveness in addressing cancer health disparities.

Possible evaluation questions related to coordinated activities include understanding the implementation process:

- What activities are planned or being undertaken (e.g., Workgroup plans)?
- How were the interventions and initiatives developed?
- Are they evidence-based?
- What was the target group?
- Were the interventions implemented as planned (i.e., fidelity)?
- What products will be produced from these activities?
- What challenges were encountered in implementing the interventions and initiatives?

Outcomes

There are three different sets of outcomes in the conceptual framework (columns 4 through 6), which are differentiated by their timing. Short-term (process) outcomes are expected to be achieved in 1 to 3 years and intermediate outcomes are expected to be achieved in 4 to 6 years. The long-term and ultimate outcomes, at 7 or more years, would exceed the period covered by this evaluation plan. RTI worked with the Board and Workgroups to define the outcomes.

First, the NHCCC conceptual framework (see Exhibit 2-5) and the evaluation planning matrix (EPM) (Section 2.3) specify short-term or process outcomes. These measures focus on the formative aspects of the program that are used to assess the extent to which the program is being implemented as planned. Common process measures are related to elements of change that are precursors to behavioral or system changes. To illustrate these types of short-term and intermediate changes, the Precede-Proceed model has been incorporated into the NHCCC conceptual framework (Green and Kreuter, 1991). This model was originally designed as a program planning model to use in applying underlying theories (e.g., socio-ecological level) to an intervention. The goal was to identify and implement the most appropriate strategies (Glanz et al., 1997). In other words, an assessment and plan would precede initiating an intervention or evaluation.

The Precede part of the model was developed in the 1970s, and it is an acronym representing factors that influence any given health behavior (Green and Krueter, 1991). A description of these factors follows:

- *Predisposing factors* are those antecedents to behavior that provide the rationale or motivation for individual behavior. As shown in the short-term outcomes in the

NHCCC conceptual framework (see Exhibit 2-5), these predisposing factors might include changes in individual knowledge, beliefs, attitudes, and values about issues related to cancer.

- *Reinforcing factors* provide the continuing reward or incentive (e.g., reinforcement) for the targeted behavior. These are generally system- or community-level changes that support individual behavioral change. Examples related to the Plan include increases in health professionals' knowledge and sensitivity related to cultural compassion, increases in understanding of issues affecting cancer control among disparate populations, and mobilization to support and positively impact community norms related to sun safety (see Exhibit 2-5, short-term outcomes).
- *Enabling factors* provide the motivation for and facilitate the realization of behavior change. Examples could include improved local referral patterns among providers to enable an average risk individual to receive appropriate screening for colorectal cancer or a provider-initiated discussion of advanced directives. Such actions could provide the motivation for the individual patient to receive more adequate cancer care. These factors are depicted in the NHCCC conceptual framework as intermediate outcomes (see Exhibit 2-5). Defining these components and their relationship to each other will enable the Board to see how and why the change strategies will work.

After describing the program, the next step is to focus the evaluation planning. The purpose of the focusing process is to clarify the design and assess the feasibility and practicality of the design. For instance, what does the Board want to learn from the evaluation? What are the overarching evaluation questions? What are the intended outcomes (short-term, mid-term, and long-term by a timeline)? How will the Board demonstrate progress? How will the Board measure its achievement? What are the data sources? Who will use the evaluation findings?

2.3 Focus the Evaluation Plan (Evaluation Design) (Step 3)

The Workgroup Chairs and Co-Chairs and the NHDHHS Project Director were engaged in determining the overarching evaluation questions:

- Overall, how successful was New Hampshire in engaging its key partners to implement *A Call to Action 2010*?
- What factors influenced implementation of the Plan (i.e., facilitators and barriers)?
- To what extent did New Hampshire achieve its short-, intermediate-, and long-term outcomes?

These questions directly relate to the implementation objectives outlined in the plan: "The most important determinant of the success of the cancer plan is the degree to which it is implemented and the objectives identified by the workgroups become realities. Crucial to achieving this success will be the sustainability of the New Hampshire Comprehensive Cancer Collaboration" (NHCCC, 2005, p. 40). Having defined these overarching questions, the next step was to define measures for each strategy and objective and indicators of success.

The EPM of activities, outputs, outcomes, and data sources mirrors, but extends, the conceptual framework (see Exhibit 2-5) and the logic models (Appendix B). A useful planning tool, the EPM was developed as a means to organize the evaluation planning process. It provided a method to explicitly define the link between activities (*what the Board, Workgroups, and their partners will do*), outcomes (*what they will achieve*), and methods (*how they will measure achievement*). Ultimately, they all link to the Board's vision "for cancer incidence, morbidity, and mortality to be significantly reduced or eliminated." Again, this planning process focused on the 41 top priority strategies selected by the Board, Workgroup Chairs, and Co-Chairs.

The Workgroup Chairs/Co-Chairs, NHCCC Manager, and NHDHHS staff participated in development of the matrix. They reviewed the preliminary draft and provided input. RTI then revised the EPM based on their input and feedback. This iterative process of creating and refining the EPM focused the evaluation planning. Each section of the matrix is described below:

- *Goal:* The EPM is organized around the five goals that were taken directly from the plan, *A Call to Action 2010*.
- *Program Focus*: The priority strategies were categorized by the Workgroup Chairs and the budget contractor during the development of the budget proposal to C-Change during July 2006.
- *Top 41 Priority Strategies:* The 41 (of 91) strategies selected by the Board and Workgroups will focus their implementation efforts during the next 5 years.
- *Partners' Planned Activities:* Activities are those tasks that would need to be completed to implement the strategies in *A Call to Action 2010*. Many of the activities in the EPM were listed in the work plans of the Workgroup Chairs and Co-Chairs. They also include the resources committed and activities undertaken by the Board and the partner organizations to ensure implementation of the respective strategies.
- *Outputs/Products:* They are the tangible evidence of activities that are completed by the Board, Workgroups, and their partner organizations in implementing the respective strategies. Examples include actual products created, such as educational materials, assessment plan, and technical assistance tools, and services delivered (e.g., training, technical assistance sessions).
- *Short-term Outcomes (1–3 years):* These outcomes are measures that assess individual- and provider-level changes in knowledge, attitudes, and beliefs achieved in years 1 through 3 if the Board and its partner organizations implement the activities as planned.
- *Intermediate Outcomes (4–6 years)*: The more long-term organizational, community, and system-level changes are expected to occur within years 4 to 6.
- *Performance Measures*: Qualitative or quantitative measurements that determine whether the target goal or outcome was met (e.g., screening rate of eligible population, service utilization, program efficiency, cost-effectiveness). Examples include the proportion of primary health care providers in New Hampshire that discuss appropriate physical activity guidelines with their patients or the proportion of New Hampshire homes tested for radon gas.

- *Current Indicator:* The baseline measure and subsequent measures indicate change over time. The baseline is usually the most recent measure prior to implementation of the plan and will be compared to future data points to indicate progress.
- *Possible Data Sources:* In the matrix, we began to specify some possible data sources that will be used to assess the outcomes for each of the priority strategies. They include extant sources (e.g., Central Cancer Registry, BRFSS, YBRS), newly developed data systems (e.g., the Strategy Implementation Tracking Tool [SITT]), and proposed data sources (e.g., provider and community surveys, worksite data). Determining which data sources are applicable and feasible will be an ongoing process.
- *Partner Organizations:* The organizations, those with primary and secondary roles, that will partner with the Board and contribute to implementing the respective priority strategy.

2.4 Gather Credible Evidence (Data Collection) (Step 4)

The data collection step focuses on gathering credible evidence to answer the questions of interest. First, it involves defining performance measures and benchmarks that will indicate NHCCC's progress in implementing *A Call to Action: 2010* and the implementation effects. Second, proposed data collection techniques are multifaceted, involving both process and outcome measures. Process evaluation addresses questions related to program operations, implementation, and service delivery (Rossi, Freeman, and Lipsey, 1999). They usually answer "how" and "what" questions and include both quantitative and qualitative measures (Yin, 2003). Potential questions include, "How many strategies did the Workgroups implement?" and "What challenges did Workgroup Chairs and Co-Chairs and the partner organizations face in implementing the strategies?" Outcome evaluation addresses the program effects or impacts (Rossi, Freeman, and Lipsey, 1999). Potential measures include the percentage of people who quit smoking and the percentage of average-risk adults aged 50 and older who are screened for colorectal cancer. Third, combining the process and outcome methods is important. It will allow for a more comprehensive evaluation and strengthens the reliability of the findings. Using mixed methods will allow NHCCC to make more confident, credible conclusions from its evaluation efforts.

The Board and the Data Workgroup will work collaboratively to identify sources for the gaps in data and information needs. They also need to address measurement challenges such as lack of population-level data. The Data Workgroup has the primary responsibility for assisting the Board and Workgroup Chairs in identifying appropriate data sources, identifying valid and reliable measures, developing an analysis plan, and completing the analysis. Potential data collection methods are described in Exhibit 2-6.

Extant data sources include population-level systems such as BRFSS and YRBS that will provide outcome measures and partners' data sets such as the mammography and colonoscopy registries. Others, like the SITT System, were developed for NHCCC by RTI to track and document process measures.

Exhibit 2-6. Data Collection Matrix

Potential Method	Description of Method	Frequency of Data Collection	Responsible Person(s)	Possible Data Elements
Record Abstraction	Review of written documents that provide information about one or more of the program components. Documents can include minutes from the Board and Workgroups, media articles, budgets, contracts, policy statements, work plans, and interview transcripts.	Monthly	NHCCC Manager and interns	• Board attendance • Leveraged resources • Policy changes
Strategy Implementation Tracking Tool (SITT)	A customized Access database that was created for NHCCC to collect details on ongoing program activities	Quarterly	NHCCC Manager and interns	• Partner organizations • Amount and type of leveraged resources • Number and type of activities • Implementation status for each strategy
Face-to-face Interviews and/or Focus Groups	Collection of qualitative data from management, patients, participants, partners, and/or other key stakeholders to assess need or capture lessons learned related to some critical aspect of the program or Plan implementation	Annual or ad hoc	Evaluator Data Workgroup	• Key stakeholders' perceptions of program success (i.e., significant change that has resulted) • Lessons learned on each aspect of plan implementation • Barriers and facilitators to implementing the Plan
Survey Instruments	Standardized and validated instruments to capture a specific aspect of Plan implementation	Annual	Evaluator Data Workgroup	• Partnership synergy • Satisfaction with Plan • Providers' survey
Network Analysis	A method to indicate the level of inter-organizational collaboration	Baseline and endpoint	Evaluator Data Workgroup	• Structural properties of the NHCCC partners' network (e.g., density, intensity, centrality, multiplexity)
Population-level Systems (e.g., BRFSS, YRBS, registries)		Annual or semiannual	Evaluator Data Workgroup	• Screening rates • Quit attempts • Sun safety attitudes and behaviors

SITT is a customized Microsoft Access 2003 relational database developed for NHCCC as a tool to assist the Board in systematically tracking implementation of the plan (see screenshots in Appendix C). All activity related to a strategy is also linked to the respective goal and priority objective. The database consists of nearly 100 data fields, a primary activity reporting form, and seven supplemental activity forms that capture information specific to the program focus area (see data elements in Appendix D). For example, information on paid media would be quite different from information on activities related to advocacy and policy change.

The NHCCC Board Manager, who will be the primary user of the tool, and the NHDHHS Project Director were engaged in every phase of database development, from defining the data fields to testing the alpha and beta versions. Two principles guided the conceptualization and development of SITT (i.e., utility and feasibility); a third principle, accuracy, must guide implementation of the database:

- *Utility*: Who needs the information and what information do they need? For every data element, the relevant question became how would NHCCC use the data. The NHCCC Board Manager and NHDHHS Project Director made the final determination about data fields and reports.
- *Feasibility*: How much money, time, and effort can New Hampshire commit to the data collection? Are the proposed data elements realistic given the available time, resources, and expertise? How will the Board collect the information from the partners? How frequently? Ultimately, those decisions will be made by the Board and the NHCCC Manager to maximize use of tracking tool.
- *Accuracy*: How will the Board ensure the accuracy of information being self-reported by the partners? It will be important for NHCCC to implement some reliability checks.

2.5 Justify Conclusions (Data Analysis and Interpretation) (Step 5)

Data analysis during the implementation phase will be ongoing, based on data collection during the relevant time period (e.g., baseline). This section provides a brief overview of the data analysis related to the main data collection methods that are detailed in the data collection matrix (see Exhibit 2-6).

2.5.1 Qualitative Methods

Qualitative data, such as document reviews, interviews, and focus groups, could be extracted/transcribed, coded, and analyzed using software such as Atlas.ti. Codes could be developed a priori based on the evaluation questions or identified inductively as they emerge from interviews and observations. Coded data could be analyzed across the respondents and combined according to some attribute. For example, the data could be analyzed by workgroup or partner organization to assess differences in perspectives.

2.5.2 Network Analysis

Data on the NHCCC network could be analyzed using a social network analysis software such as UCINET (Hanneman and Riddle, 2005) to create graphic and statistical summaries at the workgroup and network levels. The specific summaries could include the following:

- *Connectedness*: A network plot (or "snapshot") of the organizational links or connections between the partner organizations. In the graphs, a node will represent each partner organization in the New Hampshire comprehensive cancer control network and will be connected by lines to indicate the presence of a directional or nondirectional relationship. The color and shape of the nodes could denote the five NHCCC network domains (e.g., primary prevention, early detection, treatment) or some other criteria for the partner organization. If the network is connected, there will be a path or line between all partners across all workgroups.
- *Density*: A measure of interconnectedness expressed as the proportion of ties observed in a network relative to the total possible number of ties (i.e., the recommended and actual NHCCC partners within the network). The range of density scores is 0 to 1.0.
- *Degree of centrality*: The actual number of links of a particular type maintained by the average agency. It will be used to determine the important partners in each network. Organizational partners with high scores would be well connected or central (i.e., have positional advantage or influence). For example, in the NHCCC network, the U.S. Attorney Office would be expected to have a high score given its critical role.
- *Unconfirmed and confirmed scores for density and degree of centrality*: the gap in perception of involvement by one agency that may not be shared by other agencies in the network. Unconfirmed ties may reflect network potential and can be useful in capacity building through noting loose connections that could be developed into stronger ties. In other words, identifying the gaps between confirmed and unconfirmed ties could be used to suggest ways to strengthen the inter-organizational network of cancer control partners.
- *Network multiplexity*: An indicator of whether partners are collaborating in multiple ways. This measure could be used to compare the level of collaboration that is reported at baseline to some endpoint. A network score greater than 1 would indicate network multiplexity.

Collectively, these indices could be used to identify basic network characteristics, the type of interaction, the success of the Board in building bridges between components of the networks, and missing or conflicted links within the network.

2.5.3 Strategy Implementation Tracking Tool (SITT)

Most analyses related to SITT will involve producing descriptive statistics (e.g., frequencies, cross-tabulations). Some potential measures include the

- number and type of activities conducted,
- number and type of partner organizations,
- number and type of strategies implemented,
- amount of funds leveraged,

- total amount of non-CDC grant dollars received by partners and/or the Board for implementation of the Plan by fiscal year,
- proportion of total non-CDC implementation funds that were leveraged and committed by the partners, and
- proportion of partners that provided in-kind resources for implementing the Plan.

The SITT database is designed to capture these types of data over time and can be aggregated by different time periods such as months, quarters, or calendar or fiscal years. The data also can be imported into other analysis packages such as SPSS or SAS.

Ultimately, the Board, Workgroups, and program staff will need to work together to summarize and interpret the findings and to draw conclusions about the program's progress.

2.6 Ensure Use and Share Lessons Learned (Dissemination) (Step 6)

In this final step, the program defines the audience for the evaluation findings and the method and frequency for sharing the results. Disseminating and communicating evaluation results to the appropriate audience in a timely and factual manner is an important step in program evaluation. Planning for that step should not be overlooked. A familiar adage reminds us, "Only what gets measured gets attention. Only what gets attention gets fixed" (USDHHS, 1997). In other words, sharing the results can ensure use; improve plan implementation; inform policy makers, cancer control stakeholders, and the public about what is being accomplished; and leverage additional resources for comprehensive cancer control efforts. In CDC's Program Evaluation Framework, Step 6 *(Ensure Use and Share Lessons Learned)* completes and reinitiates the cycle as it feeds back to Step 1 *(Engage the Stakeholders).*

The Board and the Data Workgroup will make the final determination about who the stakeholders are, how it will disseminate the evaluation findings, and the frequency of dissemination. However, potential dissemination strategies and stakeholder groups include the following:

- Quarterly Monitoring Reports to the Board, Workgroup Chairs/Co-Chairs, and Partner Organizations
- Annual *A Call To Action 2010 Report Card* to policy makers, media, etc.
- Final Program Implementation and Evaluation Report: Years 1-5 to the Board, Workgroups, partner organizations, policy makers, and program staff
- Charting Progress toward Year 2010 Benchmarks: Comprehensive Cancer Control Outcomes Report to the Board, Workgroups, partner organizations, policy makers, and program staff)
- Presentations to local, state, regional, and national conferences and forums
- Articles in scientific journals, Web, and other publications

2.7 Summary

During the 9-month evaluation planning effort, RTI adhered to the systematic six-step process and principles outlined in CDC's "Framework for Program Evaluation in Public Health." Identified as the key stakeholders, NHCCC Board members, Workgroup Chairs and Co-Chairs, Managers, and the NHDHHS Project Director participated through face-to-face meetings, telephone interviews, conference calls, and e-mail communication to guide the development of the evaluation plan and to provide input into every aspect of the process. Through varying levels of participation, they identified the evaluation priorities, determined the overarching evaluation questions, recommended performance measures and data sources, and pilot-tested the NHCCC database. The value of this iterative, participatory process was to ensure the feasibility of the final evaluation plan and the usefulness of final products.

Through this process, several tools were created to assist NHCCC in evaluating its comprehensive cancer control plan. First, RTI developed a theoretically-based conceptual framework to depict how the comprehensive, multilevel program is expected to work as well as logic models for its five workgroups. Describing the components of the program and the relationships between them, the framework and the logic models will help NHCCC to explain its efforts to its broad group of stakeholders, policy makers, and the public. A second tool, the EPM, explicitly linked outcomes from the logic model to performance measures and data sources. It will be useful in further defining feasible strategies and setting additional priorities. Third, RTI developed a customized Microsoft Access 2003 relational database of nearly 100 data elements to help NHCCC systematically track the plan implementation. It will be useful in collecting data to document the program's effort, evaluate the implementation process, and institute mid-course corrections. The written evaluation plan will guide the NHCCC Board through the initial implementation phase of *A Call to Action 2010*. Section 3 outlines steps for moving the evaluation forward.

3. RECOMMENDATIONS AND NEXT STEPS

The primary goal of this evaluation planning was to systematically create an evaluation plan to assist NHCCC in tracking implementation of its CCC plan and assessing its accomplishments. To achieve that goal, the EPM and SITT were created as tools to guide and facilitate those processes. But they will need to be effectively used over time to receive those benefits. Next steps include strategically using and refining EPM and SITT to link activities conducted by NHCCC and its partners to program and health outcomes to be able to achieve and evaluate program improvement. The following sections outline specific recommendations for moving the Plan forward.

3.1 Evaluation Planning Matrix

If used, the EPM can be an effective tool for NHCCC to use in its ongoing assessment of activities that are underway, setting priorities for the workgroups and partner organizations, and focusing on the outcomes that best lend themselves to overall program improvement (i.e., policy change). As a next step, we recommend that NHCCC establish baseline and benchmark indicators to track its progress in meeting the program and health outcomes for all of the priority objectives and strategies. The Board has defined the baseline and benchmark indicators for 5 of the 17 priority objectives, mostly primary prevention. For example, the *Call to Action 2010* objective to increase to 80% the number of women aged 40 and older that are screened lacks a baseline measure. Other priority needs lack both. We recommend that NHCCC address these gaps immediately.

Determining which data sources are applicable and feasible is another important next step. In the matrix, we began to specify some possible data sources that could be used to assess the outcomes for each of the priority strategies. That effort can and should be expanded to explore extant sources (e.g., health services utilization data, provider surveys) that may have been unknown to those who participated in the evaluation planning process as well as proposed data sources (e.g., provider and community surveys, worksite data).

Also, we recommend that NHCCC ensure the commitment of its partners to implementing the strategies, particularly those that are listed in the matrix as having primary and secondary partners for implementing the strategies. But it is equally important to assess other partners that have a stake in implementing a particular strategy and should be but were not included in the matrix. As a next step, we recommend a baseline assessment of the level of participation and commitment of current partners and what other partner organizations need to be invited to participate in the process. As an initial step, it will be important to share the logic models and EPM and begin to establish a process for building relationships and getting buy-in. We also recommend formalizing the relationship (i.e., letters of understanding) as a means to demonstrate understanding and acceptance of their

role as a key partner organization and their commitment of resources (e.g., staff time, data, funds).

Identifying data sources for all 41 priority strategies is another immediate priority. The Board and the Data Workgroup will need to work collaboratively with all of their partner organizations to set priorities and to identify sources for the gaps in data and information needs. The Board and Data Workgroup will need to address measurement challenges such as lack of population-level data and measuring change in disparate populations. In addition to identifying appropriate data sources, the Board and Data Workgroup will need to identify valid and reliable measures and develop an analysis plan.

3.2 Strategy Implementation Tracking Tool

Assuring completeness and accuracy of data must be a priority as NHCC moves forward. We recommend several steps for doing so. First, we recommend that data collection and entry be a centralized process with designated primary and secondary staff persons that will be responsible for entering and editing the data, respectively. Having two staff persons provides a reliability check. The NHCCC Board Manager and the NHDHHS Project Director will be the primary users of the tool. They were also engaged in every phase of database development, from defining the data fields to testing the alpha and beta versions.

Second, we recommend developing an infrastructure and timeline for systematically capturing activities related to implementing the strategies. While SITT has the capacity to capture very detailed information about partners' efforts (e.g., amount and type of resources, collaborators, date initiated and completed), what will be collected will depend on the time and resources that NHCCC commit to this activity. Therefore, it is important to make reporting their activity a systematic process but minimize the burden on committed, but very busy partners. In other words, NHCCC will need to keep data collection as an important and worthwhile activity by adding value for the partners.

What do the workgroups and partners need and what format works for them? Many of the activities in the EPM were listed in the work plans of the Workgroup Chairs and Co-Chairs. As such, it may be a natural process to institutionalize review and discussion of data on a quarterly basis during the Workgroups' regular meeting. Compared with semiannual or annual reporting, quarterly assessment minimizes burden but maximizes the sense of importance of the task and recall of activities and events. Dialogue at that level will more likely happen if there is follow-up and preparation with the Chairs prior to the meeting (e.g., telephone interview) and if progress reports are provided for the Workgroup meetings. Having a set time and process gives visibility and to the process.

Third, we recommend developing a User's Manual to ensure consistency in interpretation and use of the data elements in different activities for different strategies by different partners. For example, naming conventions for open text boxes and instructions for

completing each data field will ensure consistency over time. Developing a User's Manual was not within the scope of this contract; however, RTI has provided the data definitions and a template that can be used to develop a User's Manual (see Appendix E). The manual would provide instructions for completing the data fields on each database form.

Finally, we recommend providing technical assistance and programming support to further refine the SITT database and design customized reports to meet the future information needs of the Board, Workgroups, and partner organizations. Even though SITT currently has 20 lists and eight customized reports that were developed based on the priorities of the NHCCC Managers and NHDHHS Project Director, it will be necessary to develop others (e.g., pie chart, graphs) and possibly refine the existing ones. Having quality, system-generated reports that can be e-mailed will facilitate timely sharing of progress with the Board, Workgroup Chairs, and other key stakeholders. Inability to anticipate future needs as well as resource and time limitations precludes the ability to develop every report that may be needed.

Ultimately, implementation of the Plan depends on the collaboration of the Board, Workgroups, and the partner organizations. Effectively using these evaluation planning tools, getting commitment from partners, formalizing roles and processes, consistently monitoring and broadly communicating NHCCC's progress, and making mid-course corrections will be critical to NHCCC's success.

REFERENCES

Abed, J., B. Reilley, M.O. Butler, T. Kean, F. Wong, and K. Hohman. 2000. "Developing a Framework for Comprehensive Cancer Prevention and Control in the United States: An Initiative of the Centers for Disease Control and Prevention." *Journal of Public Health Management and Practice* 6(2):67-78.

Brinkerhoff, J.M. (2002). "Assessing and Improving Partnership Relationships and Outcomes: A Proposed Framework." *Evaluation and Program Planning* 25:215-231.

Butterfoss, F.D., and M.C. Kegler. 2002. "Toward a Comprehensive Understanding of Community Coalitions: Moving from Practice to Theory." In R.J. DiClemente, R.A. Crosby, and M. C. Kegler (eds.), *Emerging Theories in Health Promotion Practice and Research* (pp. 157-193). San Francisco, CA: John Wiley & Sons, Inc.

Centers for Disease Control and Prevention. 1999. "Framework for Program Evaluation in Public Health." *Morbidity and Mortality Weekly Report* 48(RR11):1-40.

Glanz, K., F.M. Lewis, and B.K. Rimer. 1997. *Health Behavior and Health Education: Theory, Research, and Practice,* 2nd edition. San Francisco, CA: Jossey-Bass.

Green, L.W., and M.W. Krueter. 1991. "Chapter 5: Educational and Organizational Diagnosis: Factors Affecting Health-Related Behavior and Environments." In *Health Promotion Planning*, 2nd edition. Mountain View: Mayfield Publishing Company.

Hays, C.E., S.P. Hays, J.O. DeVille, and P.F. Mulhall. 2000. "Capacity for Effectiveness: The Relationship between Coalition Structure and Community Impact." *Evaluation and Program Planning* 23(3):373-379.

Hanneman, R.A., and M. Riddle. 2005. *Introduction to Social Network Methods*. Riverside, CA: University of California, Riverside. Published in digital form at http://www.faculty.ucr.edu/~hanneman/nettext/index.html.

Lasker, R.D., and E.S. Weiss. 2003. "Broadening Participation in Community Problem Solving: A Multidisciplinary Model to Support Collaborative Practice and Research." *Journal Of Urban Health: Bulletin of the New York Academy Of Medicine* 80(1):14, 47; discussion 48-60.

McLeroy, K.R., D. Bibeau, A. Steckler, and K. Glanz. 1988. "An Ecological Perspective on Health Promotion Programs." *Health Education Quarterly* 15(4):351-377.

New Hampshire Comprehensive Cancer Collaboration (NHCCC). 2005. Cancer in New Hampshire: A Call to Action 2010. Accessed May 4, 2007, at *http://cancercontrolplanet.cancer.gov/state_plans/New_Hampshire_Cancer_Control_Plan.pdf.*

Patton, M. Q. (2002). *Qualitative Research & Evaluation Methods, 3rd Edition*. Thousand Oaks, CA: Sage Publications.

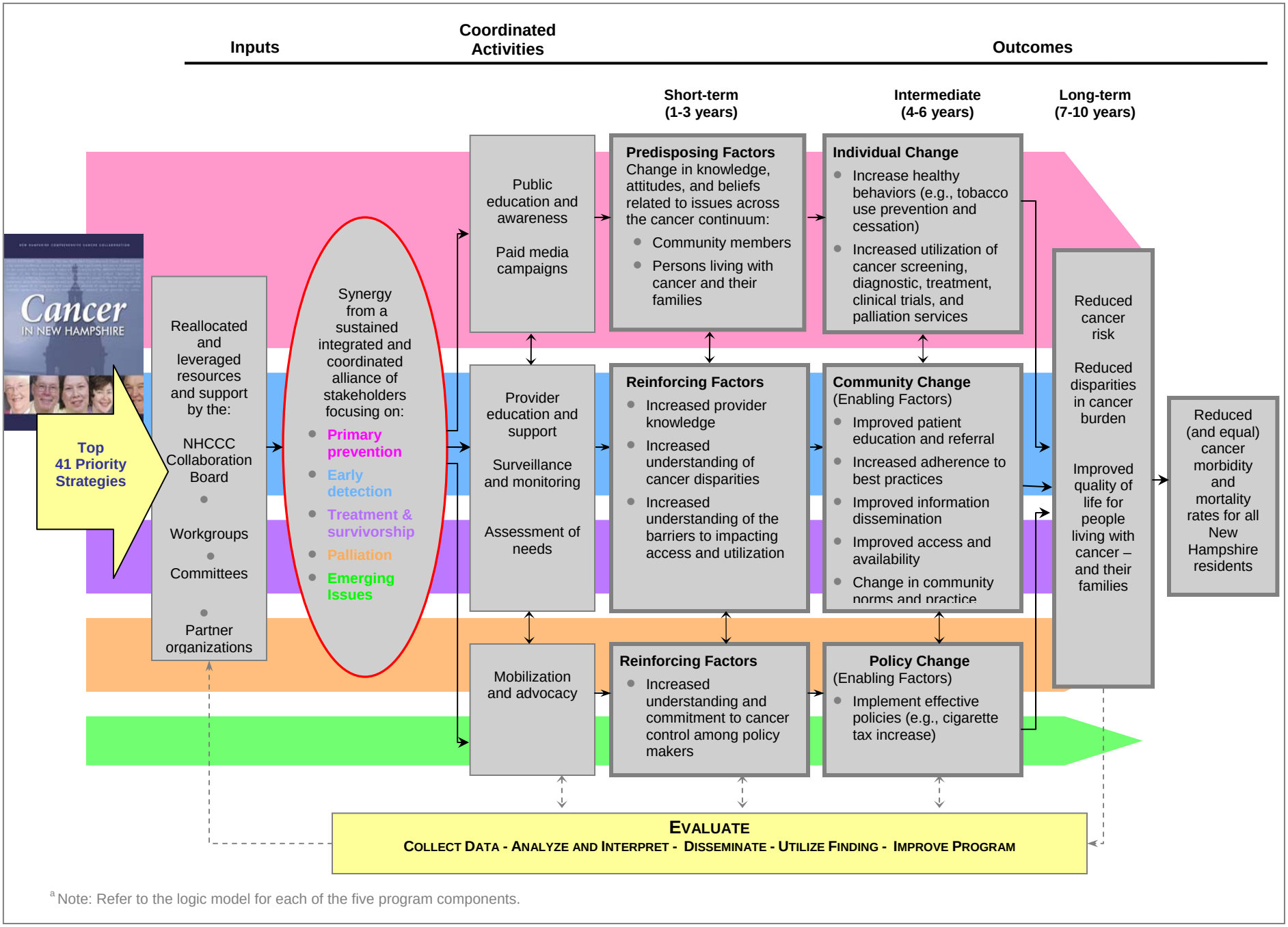
Rossi, P.H., H.E. Freeman, and M.W. Lipsey. 1999. *Evaluation: A Systematic Approach*. 6th edition. Thousand Oaks, CA: Sage.

U.S. Department of Health and Human Services (USDHHS). 1997. *Guidelines and Benchmarks for Prevention Programming: Implementation Guide* (No. (SMA) 95-3033). Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention.

Yin, R.K. 2003. *Case Study Research: Design and Methods, 3rd edition.* Thousand Oaks, CA: Sage.

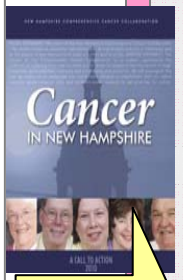
APPENDIX A:
LOGIC MODELS

Conceptual Framework for the New Hampshire Comprehensive Cancer Control Program (FINAL)[a]



[a] Note: Refer to the logic model for each of the five program components.

Logic Model for the Primary Prevention Workgroup (FINAL)



15 of 41 Top Priority Strategies

Inputs

- New Hampshire Comprehensive Cancer Collaboration Board
- Primary Prevention Workgroup
- Partner Organizations from the public, private, and nonprofit sectors
- Existing and Leveraged Resources

Synergy from a sustained integrated and coordinated inter-organizational alliance of stakeholders focusing on multiple levels of the social ecology to do:

- **Primary prevention**

Coordinated Activities

- Advocate for necessary state funding
- Develop the contracts for the media buys
- Collect and evaluate data on disparate populations
- Build key relationships
- Assess current practices and barriers
- Identify priority worksites
- Obtain the toolkits
- Engage partners; set priorities and strategies
- Engage key partners in the Workgroup.
- Identify existing initiatives.
- Assess gaps.
- Collaborate with partners to set priorities and take leadership.
- Monitor and report ongoing progress.
- Engage key partners across sectors, assess needs, design campaign, advocate for resources.
- Disseminate evidence-based information.
- Secure the necessary funding for media buys.

Outputs

- Placement of media ads on risk of SHS (2.1)
- Placement of media ads on risk of tobacco use (1.4) Annual BRFSS/YRBSS
- Awareness initiatives for providers
- Patient education tools
- Worksites' Report Card
- Smoke-free Workplace kits distributed
- Advocacy campaign to policy makers completed
- YRBS baseline data collected (6.1)
- Advocacy campaigns with policy makers (4.1, 5.1)
- Relationship-building campaigns with provider organizations
- Baselines measures for patient education
- Inventory of current policies and practices; PSAs and awareness campaign
- Evidence-based materials on UV exposure (3.1)
- Skin cancer prevention public awareness campaign (3.2)

Outcomes

Short-term (1-3 years)

- Increased public awareness of the risks of SHS (2.1)
- Increased public awareness of the risks of tobacco use
- Providers' increased awareness of the importance of tobacco prevention education (1.3)
- Employers' increased awareness of smoking cessation and benefits of smoke-free workplaces (1.2)
- Increased support for tax increase
- Positive shift in knowledge /attitudes/ beliefs among policy makers and providers
- Increased awareness of the risks associated with exposure to radon gas
- Decreased acceptability of UV exposure
- Increased awareness of UV exposure risk among targeted groups (e.g., (schools, camps, employers with outside workers)

Intermediate (4-6 years)

- Increase % of smoke-free homes/public places (PO #2)
- Decrease in the social acceptability of tobacco use
- Increase in % of providers offering cessation counseling (1.3)
- Increase in smoke-free workplaces/cessation interventions and support
- Increase in cigarette tax (≥ $1.30) by 2008 (1.1)
- Policy changes to support healthy food choices and increased physical activity (schools, worksites, community) (4.1)
- Providers' discuss appropriate physical activity guidelines with patients (5.2)
- Increase in physical activity (30 min/day for 5 days) (adults, from 50% to 24%; youth. from 50% to 27%) PO #5
- Increase daily intake of 5 servings of fruits and vegetables (adults, from 28.5% to 50%) (PO #6)
- Increase in # of homes tested for radon gas ((2.3)
- Annual increase in # of communities using the UV alert
- Decrease in exposure to UV light (PO #3)

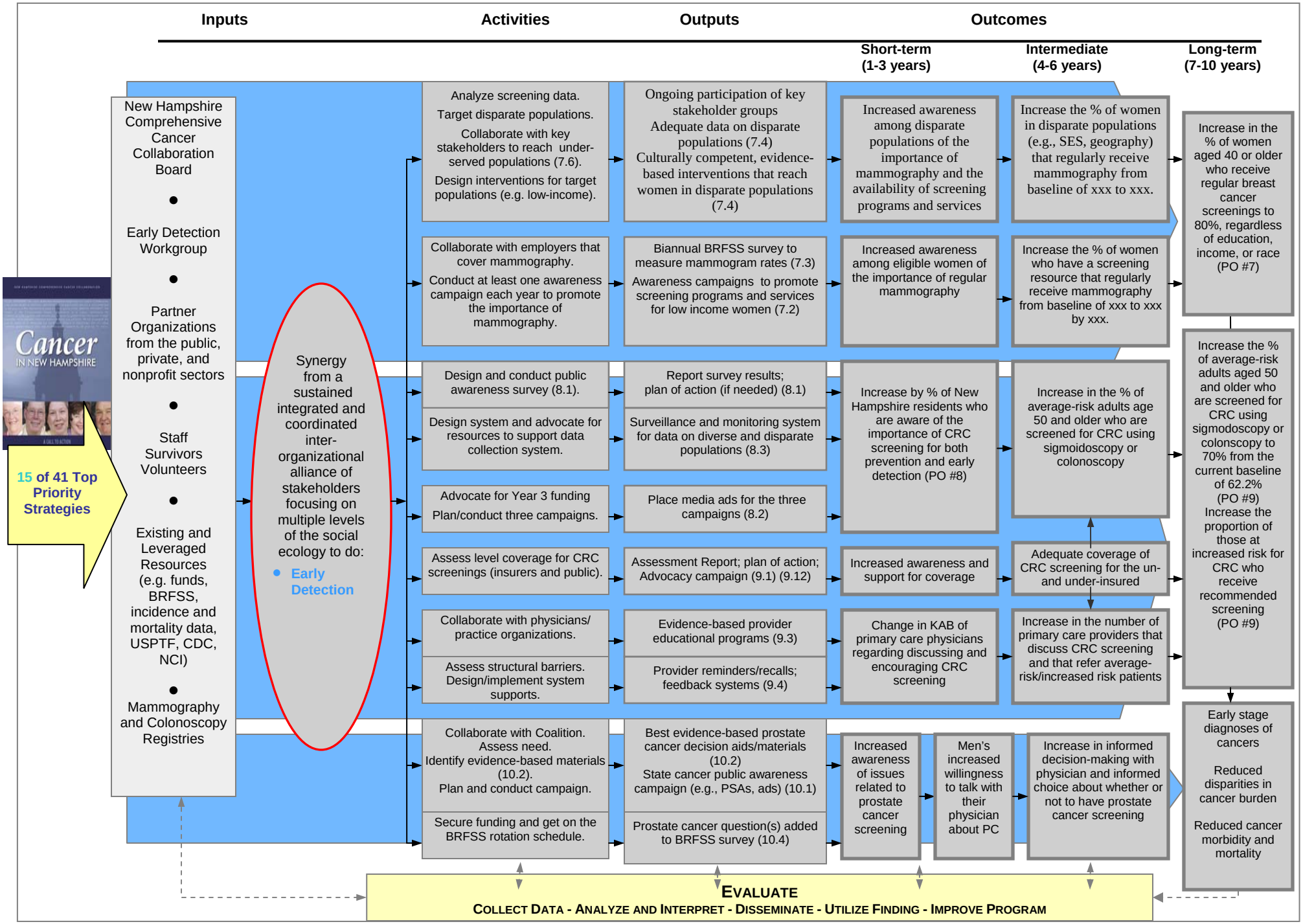
Long-term (7-10 years)

- Reduced # of residents exposed to SHS (PO #2)
- Decrease percent of residents who smoked in past month (adults from 21.7 % to 12%; youth from 19.1% to 16%) (PO #1)
- Reduced prevalence of overweight residents (adults from 50% to 40%; youth from 9.9% to 5%) (PO #4)
- Reduced number of residents exposed to radon gas (xx to xx) (PO #2)
- Prevent skin cancer (PO #3)

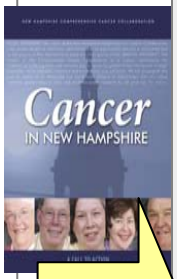
EVALUATE

COLLECT DATA - ANALYZE AND INTERPRET - DISSEMINATE - UTILIZE FINDING - IMPROVE PROGRAM

Logic Model for the Early Detection Workgroup (FINAL)



Logic Model for the Treatment and Survivorship Workgroup (FINAL)

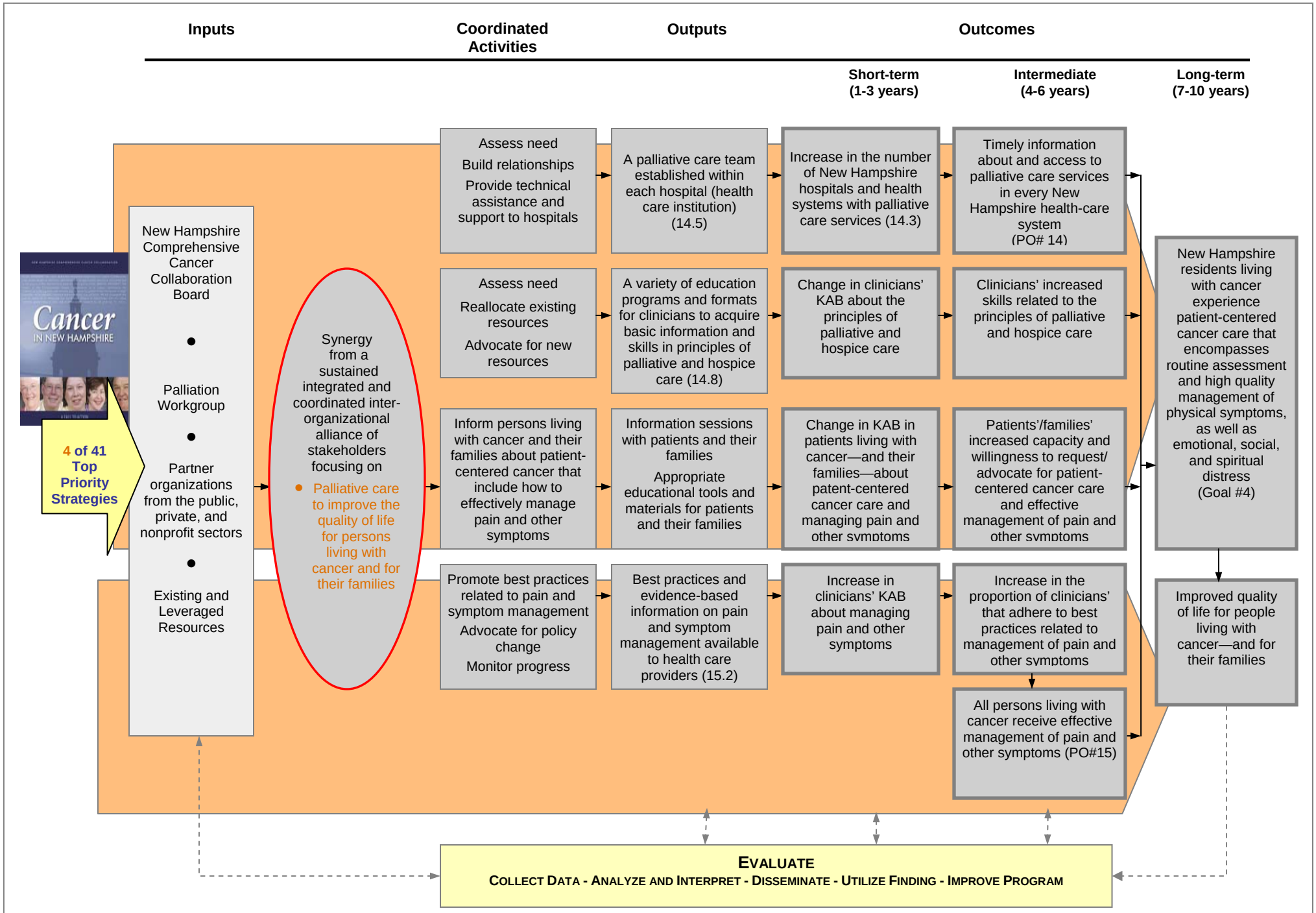


5 of 41 Top Priority Strategies

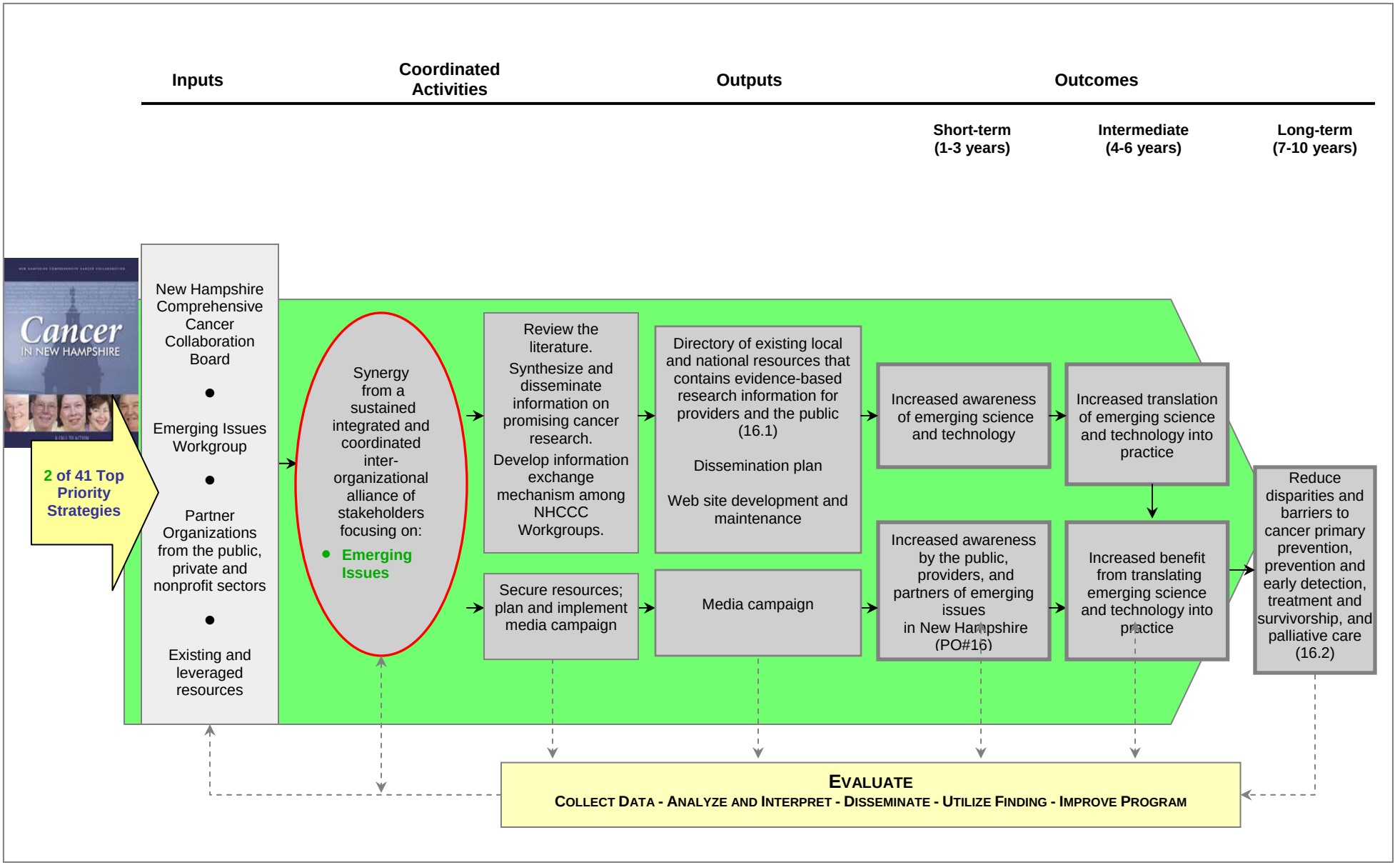
Inputs	Coordinated Activities	Outputs	Outcomes: Short-term (1-3 years)	Outcomes: Intermediate (4-6 years)	Outcomes: Long-term (7-10 years)
New Hampshire Comprehensive Cancer Collaboration Board • Treatment and Survivorship Workgroup • Partner Organizations from the public, private, and nonprofit sectors • Existing and Leveraged Resources	Identify or develop an assessment tool and/or survey; conduct the assessment.	Inventory of existing local, state, and national resources for cancer treatment and survivorship (11.1)	Increased awareness of existing resources, gaps in services, access issues, and priorities for evolving patient resources	Increased networking and coordination among partner organizations to support existing and evolving resources	Availability and accessibility of quality cancer treatment for all New Hampshire residents Decreased morbidity and mortality Improved quality of life for cancer survivors
	Conduct focus groups with patients, caregivers, health care providers, and advocacy organizations.	Data on treatment and support needs for persons who experience cancer as a long-term or ongoing chronic disease (11.4)	Increased awareness of the needs related to cancer as a chronic disease	Increased treatment and support services for persons who experience cancer as a long-term or ongoing process	
Synergy from a sustained integrated and coordinated inter-organizational alliance of stakeholders focusing on • **Treatment and Survivorship**	Identify or develop assessment tool and/or survey. Conduct assessment.	Data on the barriers to participation in clinical trials in NH; baseline data on availability of clinical trials; a plan of action to address barriers (12.1)	Increased awareness of the barriers to participating in clinical trials	Policy and system changes by organizations to facilitate participation In clinical trials	
	Develop and implement a plan of action for educating the public.	Public education campaign/ programs to promote the value and availability of clinical trials to the general public (12.3).	Increased awareness among the public about the value and availability of clinical trials.	Increase in the number of New Hampshire residents participating in clinical trials (PO#12)	
	Develop and implement a plan of action for health care providers.	Educational programs to promote the value of clinical trials to health care providers (12.3)	Increased awareness among health care providers of the value of clinical trials	Increase in the number of providers who inform patients about and provide access to available clinical trials.	
	Collaborate with and support lead partner organizations in conducting programs. Monitor and report progress.	Educational programs on the use of Advanced Care Directives and Do Not Resuscitate (DNR) orders (13.1)	Increased awareness of 2007 legislation Change in KAB about introducing and discussing advanced-care directives/DNR	Increase in the number of providers who discussed and, if appropriate, initiated Advanced Care Directives and Do Not Resuscitate (DNR) orders with their patients (PO#13).	

EVALUATE
COLLECT DATA - ANALYZE AND INTERPRET - DISSEMINATE - UTILIZE FINDING - IMPROVE PROGRAM

Logic Model for the Palliation Workgroup (Final)



Logic Model for the Emerging Issues Workgroup (FINAL)



APPENDIX B:
EVALUATION PLANNING MATRIX

EVALUATION PLANNING MATRIX - NEW HAMPSHIRE COMPREHENSIVE CANCER COLLABORATION

Goal #1 Primary Prevention: Reduce and prevent risk by living a healthy lifestyle

Priority Objective 1: Decrease the percentage of people who report cigarette smoking in the past month among youth from 19.1% to 16% and in adults from 21.7% to 12%.

(A) Program Focus	(B) *Top 41* Priority Strategies	(C) Partners' Planned Activities	(D) Intended Outputs/Products	(E) Short-term Outcomes (1–3 years)	(F) Intermediate Outcomes (4-6 years)	(G) Performance Measure	(H) Baseline/ CTA2010 Indicators	(I) Data Source	(J) Partner Organizations
Advocacy	1.1.Increase cigarette tax to at least $1.30 by 2008.	Media advocacy campaign in support of tobacco tax increase.	Radio and newspaper ads in support of tobacco tax increase Public opinion poll indicating support for tobacco tax increase Legislation filed	Increased support for raising NH tobacco tax by 50 cents among media, public, and policy makers.	Policy change; increase in NH tobacco tax passed.	Increase cigarette tax to $1.30 or more.	Baseline (2007): $0.80 2008: $1.30 2010:	NH Dept. of Revenue Admin.	NHCCC Primary Prevention Workgroup, ACS, AHA, ALANH, CFTFK
Public Education and Awareness	1.2 Educate employers about smoking cessation and the benefits of a smoke-free workplace, including college campuses.	Identify priority worksites (e.g., those not covered by NH Indoor Smoking Act). Obtain the Smoke-free Worksite kits and disseminate to targeted NH employers.	Worksites' Report Card (e.g., NH smoke-free workplaces not covered by NH Indoor Smoking Act; availability of cessation programs for employees). Smoke-free workplace kits distributed to targeted NH employers.	Increased awareness among NH employers regarding the benefits of smoke-free workplaces in NH. Increased support for employee smoking cessation programs	Increase in the number of smoke-free workplaces and cessation services for employees.	Percent of all worksites that are smoke-free Percent that have cessation programs for their employees.	Smoke-free worksites Baseline (2007): xx% 2010: xx% Employee cessation services Baseline 2007: xx% 2010: xx%	Employer survey	NHCCC, ACS, AHA, ALANH, CFTFK
Provider Education and Support	1.3 Educate health care professionals about the importance of tobacco prevention education and increase the percentage of health care providers who offer tobacco cessation counseling to patients and their families.	Build relationships. Assess current practices and barriers. Produce and disseminate to targeted health care professionals.	Awareness initiatives for providers Patient education tools	Health care providers' increased awareness of the importance of tobacco use prevention and cessation.	Increase in the percentage of health care providers who offer tobacco cessation counseling to patients and their families	Percent of health care providers who offer tobacco cessation counseling to patients and their families.	Baseline (2007): xx% 2010: xx%	Health Care Provider Survey Focus Groups	NHCCC, NHMS, NHHA, FHC
Paid Media	1.4 Conduct a media campaign for the public regarding the importance of tobacco use prevention and cessation.	Advocate for necessary funding. Develop contracts for the media buys. Collect and evaluate data on disparate populations.	Communications (e.g., letters, e-mail) to editors and policy makers Placement of media buys on risk of tobacco use	Increased awareness among the NH public about the risk of tobacco use and the importance of tobacco use prevention and cessation.	Decreased social acceptability of tobacco use.	Percent of adults and youth that are current smokers (smoked one cigarette in last 30 days) Percent of adults and youth that report quit attempts to quit Percent of residents that are awareness of the importance of tobacco use prevention and cessation	Baseline (2007): xx% 2010: xx%	BRFSS Public opinion survey	NHCCC, NHDHHS, ACS, TFAN Action Network, CFTFK

EVALUATION PLANNING MATRIX - NEW HAMPSHIRE COMPREHENSIVE CANCER COLLABORATION

Goal #1 Primary Prevention: Reduce and prevent risk by living a healthy lifestyle									
Priority Objective 1: Decrease the percentage of people who report cigarette smoking in the past month among youth from 19.1% to 16% and in adults from 21.7% to 12%.									
(A) Program Focus	**(B) *Top 41* Priority Strategies**	**(C) Partners' Planned Activities**	**(D) Intended Outputs/Products**	**(E) Short-term Outcomes (1–3 years)**	**(F) Intermediate Outcomes (4-6 years)**	**(G) Performance Measure**	**(H) Baseline/ CTA2010 Indicators**	**(I) Data Source**	**(J) Partner Organizations**
Surveillance	1.7 Continue to survey public regarding tobacco use, utilizing the NH Behavioral Risk Factor Surveillance System and Youth Risk Behavior Survey.	Advocate for needed resources to continue the surveillance of risky behaviors.	Biannual survey	BRFSS and YRBS surveys completed	Decrease in the percentage of adults and youth using tobacco products Increase in smokers who attempt to quit	Percent of adults and youth that report using tobacco products	<u>Youth</u> Baseline (2006): 19.1% 2010: 16% <u>Adult</u> Baseline (2006): 21.7% 2010: 12%	BRFSS YRBS	NHCCC, NHDHHS
Disparate Populations	1.8 Collect and evaluate data on tobacco use in disparate populations and develop interventions.	Oversample disparate populations.	Smoking prevention and cessation materials translated into three languages	Development and analysis of data regarding tobacco use among disparate populations	Development and analysis of data regarding tobacco use among disparate populations	Percent of disparate groups that report using tobacco products	Baseline (2006): xx% 2010: xx%	BRFSS YRBS	NHCCC, NHDHHS, NHMHC

EVALUATION PLANNING MATRIX - NEW HAMPSHIRE COMPREHENSIVE CANCER COLLABORATION

Goal #1 Primary Prevention: Reduce and prevent risk by living a healthy lifestyle

Priority Objective 2: Reduce the number of people in New Hampshire exposed to second-hand smoke in public places through increasing the number of places that are smoke free and reduce exposure to radon gas in homes.

(A) Program Focus	(B) *Top 41* Priority Strategies	(C) Partners' Activities	(D) Outputs/Products	(E) Short-term Outcomes (1–3 years)	(F) Intermediate Outcomes (4-6 years)	(G) Performance Measure	(H) Baseline/2010 Indicator	(I) Data Source	(J) Partner Organizations
Paid Media	2.1.Utilize a mass media campaign to educate the public on the risks of second-hand smoke exposure in the home, workplace, etc.	Advocate for necessary funding Develop contracts for the media buys Collect and evaluate data on disparate populations.	Letters to editors and policymakers Placement of media buys on risk of exposure to second-hand smoke. Survey results	Increased awareness among the public of the risks of second-hand smoke exposure.	Increase in the percentage of smoke-free homes and workplaces in New Hampshire.	Percent of residents that are aware of the risks of second-hand smoke exposure Percent of smoke-free homes and workplaces in New Hampshire.	Smoke-free homes Baseline (2007): xx% 2010: xx% Smoke-free public places Baseline (2007): xx% 2010: xx%	BRFSS Community and Employer surveys	NHCCC, ACS, AHA, ALANH, CFTFK
Surveillance	2.3 Increase the number of New Hampshire homes tested for radon gas.	Engage key partners across sectors Assess needs Design campaign Advocate for resources Conduct campaign	Inventory of current policies and practices PSAs, newspaper ads Flyers and printed materials targeted to homeowners regarding the risk of radon gas.	Increased awareness of the risks associated with exposure to radon gas	Increase in number of homes in NH tested for Radon Gas	Percent of NH homes that have been tested for radon gas.	Baseline (2007): xx% 2010: xx%	Survey Data	NHCCC, NHDHHS, Chamber of commerce, Real Estate Association

EVALUATION PLANNING MATRIX - NEW HAMPSHIRE COMPREHENSIVE CANCER COLLABORATION

Goal #1 Primary Prevention: Reduce and prevent risk by living a healthy lifestyle									
Priority Objective 3: Prevent skin cancer in New Hampshire by decreasing exposure to ultraviolet light.									
(A) **Program Focus**	**(B)** ***Top 41*** **Priority Strategies**	**(C)** **Partners' Activities**	**(D)** **Outputs/Products**	**(E)** **Short-term Outcomes (1–3 years)**	**(F)** **Intermediate Outcomes (4-6 years)**	**(G)** **Performance Measure**	**(H)** **Baseline/2010 Indicators**	**(I)** **Data Source**	**(J)** **Partner Organizations**
Public Education and Awareness	3.1.Promote evidence-based materials on decreasing UV exposure to New Hampshire schools, ski resorts, camps, community programs, employers with outside workers, and other recreational facilities.	Secure optional funding. Disseminate evidenced-based information. Add question to BRFSS to measure KAB related to UV exposure. Establish network of partners to initiate Sun Safe policy and system changes.	Materials distribution to designated venues Question added to BRFSS Sun Safe policy and system changes	Decreased acceptability of UV exposure.	Increase in the percent of NH residents that understand risks and practice protective behaviors Adoption of Sun Safe policies and system changes by community programs and organizations Increase in the Sun Safe communities in NH	Increase in the percent of NH residents that understand risks and practice protective behaviors Increase in the number of communities using the UV Alert system	Decreased social acceptability: Baseline (2007): xx% 2010: xx% UV Alert communities: Baseline (2007): xx% 2010: xx%	BRFSS	NHDHHS, DOE, Parks and Recreation, ACS, Pediatric Association, Dermatology Association
Public Education and Awareness	3.2 Conduct a public campaign about prevention of skin cancer.	Advocate for necessary funding. Develop contracts for the media buys.	Placement of media buys PSAs and distribution of printed materials	Increased awareness among the NH public of the importance of the prevention of skin cancer. Decreased acceptability of UV exposure	Decrease in exposure to UV light among New Hampshire's population	Proportion of NH residents who report understanding the risks of skin cancer and strategies to prevent it Percent of NH residents who report having been sunburned within the last year	Baseline (2007): xx% 2010: xx%	BRFSS Public opinion and Worksite surveys	NHDHHS, ACS

EVALUATION PLANNING MATRIX - NEW HAMPSHIRE COMPREHENSIVE CANCER COLLABORATION

Goal #1 Primary Prevention : Reduce and prevent risk by living a healthy lifestyle									
Priority Objective 4: Reduce the prevalence of overweight adults from 50% to 40% and youth from 9.9% to 5%.									
(A) **Program Focus**	**(B)** ***Top 41*** **Priority Strategies**	**(C)** **Partners' Activities**	**(D)** **Outputs/Products**	**(E)** **Short-term Outcomes (1–3 years)**	**(F)** **Intermediate Outcomes (4-6 years)**	**(G)** **Performance Measure**	**(H)** **Baseline/2010 Indicators**	**(I)** **Data Source**	**(J)** **Partner Organizations**
Advocacy	4.1.Advocate for policies that promote healthy food choices in schools, the work place, and communities.	Collaborate with partners to set priorities and take leadership. Conduct advocacy campaign.	Communications with policy makers and employers that promote the link between nutrition, physical activity, and diet.	Increased awareness and support among public policy makers and employers	Adoption of policies by schools, employers, and communities to support healthy food choices and increased physical activity	Proportion of schools, workplaces, and communities that adopt policies and practices to support healthy living	Baseline for each target group (2007): xx% 2010: xx%	School and worksite surveys	NHCCC, NHDHHS, ACS, DHMC, Health Trust, Governor's Council, HDOE, BIA
Provider Education and Support	4.2 Develop relationships with health care providers to establish baseline measurements for educating their patients about a healthy weight and lifestyle.	Build collaborative relationship with provider organizations. Develop and implement a plan of action.	Baseline measures for patient education	Increase in providers' willingness to educate their patients	Increase in number of providers that discuss appropriate physical guidelines with their patients	Establishment of baseline measurements for providers to educate patients about a healthy weight and lifestyle	Measurements established.	Provider organiza-tions	NHCCC, NHDHHS, NHMS, NHHA

EVALUATION PLANNING MATRIX - NEW HAMPSHIRE COMPREHENSIVE CANCER COLLABORATION

Goal #1 Primary Prevention : Reduce and prevent risk by living a healthy lifestyle									
Priority Objective 5: Increase the percentage of adults and children who engage in physical activity for at least 30 minutes a day, 5 days a week to 50% from a baseline of 27% for youth and 24% for adults.									
(A) Program Focus	**(B) *Top 41* Priority Strategies**	**(C) Partners' Activities**	**(D) Outputs/Products**	**(E) Short-term Outcomes (1–3 years)**	**(F) Intermediate Outcomes (4-6 years)**	**(G) Performance Measure**	**(H) Baseline/2010 Indicators**	**(I) Data Source**	**(J) Partner Organizations**
Advocacy	5.1.Advocate for policies that promote increased physical activity in schools, the workplace, and communities.	Collaborate with partners to set priorities and take leadership. Conduct advocacy campaign.	Communications with policy makers and employers that promote the link between nutrition, physical activity, and diet.	Increased awareness and support among public policy makers, employers, and community leaders	Adoption of policies by schools, employers, and communities to support increased physical activity	Proportion of schools, workplaces, and communities that adopt policies and practices to support increased physical activity	Baseline for each target group (2007): xx% 2010: xx%	School and employer surveys	NHCCC, NHDHHS, NHDOE, BIA
Provider Education and Support	5.2 Encourage health care providers to discuss appropriate physical activity guidelines with their patients.	Build collaborative relationship with partner organizations. Develop and implement a plan of action.	Adoption of policies, procedures, and assistive technology to support providers	Increase in providers' willingness to educate their patients	Increase in number of providers that discuss appropriate physical guidelines with their patients	Proportion of providers that discuss appropriate physical activity guidelines with their patients	Baseline (2008): xx % 2010: xx %	Provider surveys	NHCCC, NHDHHS, NHMS, NHHA

EVALUATION PLANNING MATRIX - NEW HAMPSHIRE COMPREHENSIVE CANCER COLLABORATION

Goal #1 Primary Prevention : Reduce and prevent risk by living a healthy lifestyle									
Priority Objective 6: Increase the percentage of adults and children who eat at least five servings of fruits and vegetables every day to 50% from a baseline of 28.5% in adults.									
(A) Program Focus	**(B) *Top 41* Priority Strategies**	**(C) Partners' Activities**	**(D) Outputs/Products**	**(E) Short-term Outcomes (1–3 years)**	**(F) Intermediate Outcomes (4-6 years)**	**(G) Performance Measure**	**(H) Baseline/2010 Indicators**	**(I) Data Source**	**(J) Partner Organizations**
Surveillance	6.1.Collect baseline data regarding the intake of fruits and vegetables by New Hampshire youth using the Youth Risk Behavior Survey (YRBS).	Work with the NH Department of Education to include a question on YRBS regarding fruit and vegetable consumption.	Baseline measurement of fruit and vegetable consumption by students in grades 9-12	Initiate a measure for youth's consumption of fruits and vegetables.	Maintain a YRBS measure of consumption of fruits and vegetables.	Percent of NH youth that report eating fruits and vegetables	Baseline (2007): xx% 2010: xx%	YRBS	NHCCC, NHDHHS, NHDOE

EVALUATION PLANNING MATRIX - NEW HAMPSHIRE COMPREHENSIVE CANCER COLLABORATION

Goal #2 Early Detection: Reduce cancer morbidity and mortality by increasing the screening rates for those cancers where evidence-based guidelines exist.									
Priority Objective 7: Increase the percentage of women aged 40 or older who receive regular breast cancer screenings to 80%, regardless of education, income, or race.									
(A) Program Focus	**(B) *Top 41* Priority Strategies**	**(C) Partners' Activities**	**(D) Outputs/Products**	**(E) Short-term Outcomes (1–3 years)**	**(F) Intermediate Outcomes (4-6 years)**	**(G) Performance Measure**	**(H) Baseline/2010 Indicators**	**(I) Data Source**	**(J) Partner Organizations**
Public Education and Awareness	7.2 Conduct at least one awareness campaign to promote screening programs and services for low-income women.	Campaigns to promote awareness by targeting low-income women Identify resources for low-cost or no-cost mammography as incentives.	Placement of media buys Distribution of print materials Free mammograms for eligible women	Increased awareness among eligible women of the importance of regular mammography.	Increase in the percentage of women aged 40 and over and eligible for a screening resource that received breast cancer screening	Percent of low-income NH women age 40 and over screened through available programs and services, projected to population	Baseline (2006): xx% 2010: 80%	Mammo-graphy registry BRFSS	NHCCC, NHDHHS, ACS
Surveillance	7.3 Continue to measure mammogram rates every two years through the BRFSS.	Include mammogram questions every two years as part of BRFSS core.	Biannual BRFSS survey data	NH mammography rates	NH mammography rates	Percent of eligible NH women over age 40 that receive breast cancer screening within previous 2 years	Baseline (2006): xx% 2010: 80%	BRFSS	NHDHHS, ACS
Disparate Populations	7.4 Collect and evaluate data on diverse and disparate populations and promote evidence-based interventions that target these women for screening.	Oversample Black, Hispanic women over age 40 and refugee women age 40 and over. Design interventions for targeted populations.	Adequate data on disparate populations Culturally competent, evidence-based interventions that reach women in disparate populations	Increased understanding of the need among diverse and disparate populations Increased awareness among disparate populations of the importance of mammography and the availability of screening programs and services	Increase in screening rates among Black, Hispanic, and refugee women age 40 and older	Percent of NH Black, Hispanic, and refugee women age 40 and older that receive appropriate breast cancer screening Percent of women in disparate populations diagnosed with late stage breast cancer	Baseline (2007): xx% 2010: 80% Baseline (2007): xx% 2010: xx%	Mammo-graphy registry BRFSS	NHDHHS, ACS
Public Education and Awareness	7.6 Collaborate with state partners, community organizations, cancer councils, faith-based organizations, or other systems to implement awareness and screening initiatives with women from underserved populations.	Identify and engage a broad representation of key partner organizations and other stakeholders from underserved populations.	Champions identified by the respective organizations Innovative joint initiatives developed based on evidence and best practices	Increased commitment to reaching women from underserved populations (e.g., extent of participation and collaboration, collective joint projects)	Increase in the number and type of education and awareness activities targeting underserved populations Increase in screening initiatives targeting underserved populations	Percent of total public education and awareness efforts that targeted underserved populations Percentage of women from underserved populations served through screening programs	Baseline (2007): xx% 2020: xx	Partner organization Screening programs	NHCCC,

EVALUATION PLANNING MATRIX - NEW HAMPSHIRE COMPREHENSIVE CANCER COLLABORATION

Goal #2 Early Detection: Reduce cancer morbidity and mortality by increasing the screening rates for those cancers where evidence-based guidelines exist.									
Priority Objective 8: Increase the percentage of New Hampshire residents who are aware of the importance of colorectal cancer screening for both prevention and early detection.									
(A) Program Focus	**(B) *Top 41* Priority Strategies**	**(C) Partners' Activities**	**(D) Outputs/Products**	**(E) Short-term Outcomes (1–3 years)**	**(F) Intermediate Outcomes (4-6 years)**	**(G) Performance Measure**	**(H) Baseline/2010 Indicators**	**(I) Data Source**	**(J) Partner Organizations**
Surveillance and Monitoring	8.1 Conduct a survey of the public to determine the percentage of the population aware of the need for colorectal cancer screening for both prevention and early detection.	Collaborate with partner organizations to identify resources. Plan and implement the survey. Report survey results. Develop a plan of action if needed.	Report on survey findings Action Plan	Increased understanding of the public's knowledge, attitudes, and behaviors related to colorectal cancer screening.	Targeted and evidence-based public education and awareness programs that address the gaps in information	Percent of the population that is aware of the need for colorectal cancer screening for both prevention and early detection	Baseline (year of survey): xx% 2010: xx%	BRFSS	NHCCC, NHDHHS,
Paid Media	8.2 Conduct at least three media campaigns in New Hampshire to increase public awareness regarding the importance of screening for colorectal cancer.	Advocate for Year 3 funding. Plan and conduct media campaign using CDC Screen for Life or ACS content and materials.	Placement of media buys for three annual campaigns	Increase public awareness of the importance of colorectal cancer screening for both prevention and early detection.	Increase the percentage of adults aged 50 and older who are aware of the importance of colorectal cancer screening.	Percent of adults aged 50 and over who are aware of the importance of CRC screening	Baseline (all groups) (2007): xx% 2010: xx%	Public opinion survey Toll-free calls tracking system	NHCCC, NHDHHS, ACS
Surveillance	8.3 Develop a plan or system to collect/obtain colorectal cancer data on diverse and disparate populations.	Advocate for resources to support data collection Design system. Oversample adults age 50 and over in disparate populations (i.e., Black, Hispanic, and refugee).	Surveillance and monitoring system CRC data for diverse and disparate populations	Increase in knowledge and understanding of CRC screening disparity.	Develop and promote evidence-based interventions for targeted populations.	Creation of a surveillance and monitoring system.	System created.		NHCCC, NHDHHS, ACS

EVALUATION PLANNING MATRIX - NEW HAMPSHIRE COMPREHENSIVE CANCER COLLABORATION

Goal #2 Early Detection: Reduce cancer morbidity and mortality by increasing the screening rates for those cancers where evidence-based guidelines exist.

Priority Objective 9: Increase the percentage of average-risk adults age 50 and older who are screened for colorectal cancer using sigmoidoscopy or colonoscopy to 70% from the current baseline of 62.2% and increase the proportion of those at increased risk for colorectal cancer receiving recommended screening.

(A) Program Focus	(B) *Top 41* Priority Strategies	(C) Partners' Activities	(D) Outputs/Products	(E) Short-term Outcomes (1–3 years)	(F) Intermediate Outcomes (4-6)years)	(G) Performance Measure	(H) Baseline/2010 Indicators	(I) Data Source	(J) Partner Organizations
Assessment	9.1 Assess insurance coverage of New Hampshire residents for colorectal cancer screenings and, if not adequate, develop a plan of action.	Survey insurers and government programs in New Hampshire to determine the level of coverage for colorectal cancer screening. Develop a strategy to obtain funding for un- and under-insured.	Report that indicates the status of health insurance coverage for colorectal cancer screening in New Hampshire Funds for indigent, un-insured, and under-insured	Increased awareness of the need for coverage Increased support for coverage by insurers and public policymakers	Policy change to increase in the number of NH residents age 50 through 64 that have adequate coverage for CRC screening	Proportion of NH employed residents for whom CRC screening is a covered insurance benefit Percent of total low income average-risk NH residents age 50 through 64 that received CRC screening, projected to population.	Baseline (2007): xx % 2010: xx%	Health Plan survey Colonoscopy registry	NHCCC, ACS
Provider Education and Support	9.3 Implement evidence-based educational programs to increase the knowledge of primary-care physicians regarding colorectal cancer screening.	Engage and collaborate with physicians and provider practice organizations. Identify funding source. Implement Concord Hospital colon cancer screening improvement project. Identify additional best practice methods.	Evidence-based programs or approaches to educate physicians on best practice related to CRC screening	Increase in knowledge of best practices for colorectal cancer screening among primary care physicians	Increased adherence by primary care providers to best practice CRC screening guidelines for average-risk and increased risk patients	Percent of primary care providers that discuss CRC screening Percent of NH adults age 50 and older reporting that their physician discussed CRC screening Percent of primary care providers that refer average-risk and increased risk patients for CRC screening	Baseline (2008): xx % 2010: xx%	Provider Survey EMR System data BRFSS	NHCCC, NHMS, ACS
Provider Education and Support	9.4 Work with primary care physicians' offices to implement an organized, systems-based approach for colorectal cancer screening.	Engage and collaborate with physicians and provider organizations to design and implement system supports such as the provider reminder system through Electronic Medical Records. Assess structural barriers.	Organized systems such as provider reminder, recall, and feedback	Increase in the prevalence and use of organized systems to support physicians	Increased adherence by primary care providers to best practice for CRC screening guidelines for average-risk and increased risk patients	Percent of primary care providers that discuss CRC screening Percent of primary care providers that refer average-risk and increased risk patients for CRC screening. Percent of health care providers that have access	Baseline (2008): xx % 2010: xx%		NHCCC, Concord Hospital, DHMC, ACS, Harvard-Pilgrim

EVALUATION PLANNING MATRIX - NEW HAMPSHIRE COMPREHENSIVE CANCER COLLABORATION

Goal #2 Early Detection: Reduce cancer morbidity and mortality by increasing the screening rates for those cancers where evidence-based guidelines exist.									
Priority Objective 9: Increase the percentage of average-risk adults age 50 and older who are screened for colorectal cancer using sigmoidoscopy or colonoscopy to 70% from the current baseline of 62.2% and increase the proportion of those at increased risk for colorectal cancer receiving recommended screening.									
(A) Program Focus	**(B) *Top 41* Priority Strategies**	**(C) Partners' Activities**	**(D) Outputs/Products**	**(E) Short-term Outcomes (1–3 years)**	**(F) Intermediate Outcomes (4-6)years)**	**(G) Performance Measure**	**(H) Baseline/2010 Indicators**	**(I) Data Source**	**(J) Partner Organizations**
Surveillance	9.11 Determine if colorectal cancer should be a yearly BRFSS question and whether the question should be modified.	Determine need for question. Secure additional resources to implement it.	Question that has been tested in other states				Question added	BRFSS	NHCCC, NHDHHS
Advocacy	9.12 Explore and secure funding for colorectal cancer screening for un- and underinsured New Hampshire residents.	Conduct an advocacy campaign to obtain funding. Design and pilot a CRC screening project for uninsured and under-insured NH residents. Design and pilot program to provide colorectal cancer screening and colonoscopy services for 600 uninsured residents through HRSA funded Community Health Centers.	Amount of funding Design of the pilot			Funding secured. Pilot project completed.		Colonoscopy registry ?? Pilot project data	NHCCC, BSPCA, Federally qualified community health centers (FQCHC)

EVALUATION PLANNING MATRIX - NEW HAMPSHIRE COMPREHENSIVE CANCER COLLABORATION

Goal #2 Early Detection: Reduce cancer morbidity and mortality by increasing the screening rates for those cancers where evidence-based guidelines exist.									
Priority Objective 10: Promote informed decision-making related to prostate cancer screening.									
(A) Program Focus	**(B) *Top 41* Priority Strategies**	**(C) Partners' Activities**	**(D) Outputs/Products**	**(E) Short-term Outcomes (1–3 years)**	**(F) Intermediate Outcomes (4-6 years)**	**(G) Performance Measure**	**(H) Baseline/2010 Indicators**	**(I) Data Source**	**(J) Partner Organizations**
Public Education and Awareness	10.1 Conduct a public awareness campaign encouraging men to talk with their physicians about prostate cancer.	Collaborate with Prostate Coalition. Identify evidence-based materials. Plan and conduct campaign.	State cancer public awareness campaign (e.g., PSAs; radio, TV, Internet, and print ads)	Increased awareness among men of importance of talking with their physicians about prostate cancer	Increased willingness and capacity to talk with their physician about prostate cancer	Percent of men that reported discussing prostate cancer and PSA testing with their physician	Baseline (2007): xx% 2010: xx%	Public opinion survey, BRFSS	NHCCC, NH Prostate Coalition , ACS
Public Education and Awareness	10.2 Identify the best evidence-based materials for a New Hampshire prostate cancer public awareness campaign.	Conduct literature review and environmental scan of potential interventions.	Evidence-based materials Best practices						NHCCC, NH Prostate Coalition, ACS
Surveillance	10.4 Add a question on the BRFSS as to whether men have discussed prostate cancer with their physician.	Secure additional resources to implement it.	Question that has been tested in other states				Question added	BRFSS	NHCCC, NH Prostate Coalition , ACS

EVALUATION PLANNING MATRIX - NEW HAMPSHIRE COMPREHENSIVE CANCER COLLABORATION

Goal #3 Treatment and Survivorship: Quality treatment shall be available and accessible to all New Hampshire residents.									
Priority Objective 11: Support existing and evolving patient resources and systems that can facilitate optimum care for cancer survivors.									
(A) Program Focus	**(B) *Top 41* Priority Strategies**	**(C) Partners' Activities**	**(D) Outputs/Products**	**(E) Short-term Outcomes (1–3 years)**	**(F) Intermediate Outcomes (4-6 years)**	**(G) Performance Measure**	**(H) Baseline/2010 Indicators**	**(I) Data Source**	**(J) Partner Organizations**
Assessment	11.1 Identify and promote existing national and local resources.	Identify or develop an assessment tool and/or survey. Conduct the assessment.	Inventory of existing local, state, and national resources for cancer treatment and survivorship	Increased awareness of existing resources, gaps in services, access issues, and priorities for evolving patient resources	Increased networking and coordination among partner organizations to support existing and evolving resources Increased support for developing services			Survey	NHCCC
Assessment	11.4 Identify specific treatment and support needs for persons who experience cancer as a long-term or ongoing process.	Conduct focus groups with patients, caregivers, health-care providers, and advocacy organizations.	Data on treatment and support needs for persons who experience cancer as a long-term or ongoing chronic disease	Increased awareness of the needs related to living with cancer as a chronic disease	Increased treatment and support services for persons who experience cancer as a long-term, ongoing process	Percent of cancer survivors who receive comprehensive care from an approved cancer center	Baseline (2007): xx% 2010: xx%	Cancer registry	NHCCC, NHDHHS

EVALUATION PLANNING MATRIX - NEW HAMPSHIRE COMPREHENSIVE CANCER COLLABORATION

Goal #3 Treatment and Survivorship: Quality treatment shall be available and accessible to all New Hampshire residents.									
Priority Objective 12: Increase the number of New Hampshire residents participating in cancer-related clinical trials.									
(A) Program Focus	**(B) *Top 41* Priority Strategies**	**(C) Partners' Activities**	**(D) Outputs/Products**	**(E) Short-term Outcomes (1–3 years)**	**(F) Intermediate Outcomes (4-6 years)**	**(G) Performance Measure**	**(H) Baseline/2010 Indicators**	**(I) Data Source**	**(J) Partner Organizations**
Assessment	12.1 Identify and address barriers to participating in clinical trials in New Hampshire.	Identify or develop an assessment tool and/or survey. Distribute tool to 95% of facilities that provide cancer treatment. Compile and analyze the findings from the assessment. Disseminate report.	Baseline data on the availability of clinical trials in NH Data on barriers to participating in clinical trials in NH A plan of action to address identified barriers.	Increased awareness of the barriers to participating in clinical trials	Policy and system changes by organizations to facilitate participation in clinical trials	Percentage of cancer patients participating in clinical trials	Baseline (2007): xx% 2010: xx%	NCI clinical trials database Clinical Trials Survey	NHCCC
Public Education and Awareness	12.3 Encourage educational and promotional opportunities that explain the value of clinical trials to the public.	Develop a plan of action for health care providers. Collaborate with and support lead partner organizations in designing and conducting public education programs. Public education campaign/programs to promote the value and availability of clinical trials. Monitor and report progress.	A plan of action Education programs to promote the value of clinical trials to health care providers. Media and educational materials to promote the value and availability of clinical trials.	Increased awareness among health care providers of the value of clinical trials Increased awareness among the public of the value and availability of clinical trials.	Increase in the number of providers who inform patients about and provide access to available clinical trials. Increase in the number of New Hampshire residents who request information on clinical trials.	Percentage of cancer patients participating in clinical trials	Baseline (2007): xx% 2010: xx% Baseline (2007): xx% 2010: xx%	NCI clinical trials database Clinical Trials Survey	NHCCC ACOS liaison physician

EVALUATION PLANNING MATRIX - NEW HAMPSHIRE COMPREHENSIVE CANCER COLLABORATION

Goal #3 Treatment and Survivorship: Quality treatment shall be available and accessible to all New Hampshire residents.									
Priority Objective 13: Ensure the availability of a protocol for the introduction and discussion of advanced-care directives and other end-of-life issues.									
(A) Program Focus	**(B) *Top 41* Priority Strategies**	**(C) Partners' Activities**	**(D) Outputs/Products**	**(E) Short-term Outcomes (1–3 years)**	**(F) Intermediate Outcomes (4-6 years)**	**(G) Performance Measure**	**(H) Baseline/2010 Indicators**	**(I) Data Source**	**(J) Partner Organizations**
Provider Education and Support	13.1 Ensure that all appropriate providers have access to educational programs on the use of advanced directive and DNR (Do Not Resuscitate) orders.	Collaborate with and support lead partner organization in conducting programs to educate providers about the legislation, HB 656.	Educational programs on the use of Advanced Care Directives and Do Not Resuscitate orders	Physicians' increased awareness of the advance directives and DNR provisions in 2007 legislation (HB 656) Change in KAB about introducing and discussing ACD/DNR	Increased discussion about and initiation of ACD/DNRs by the physicians.				NHCCC Foundation for Healthy Communities

EVALUATION PLANNING MATRIX - NEW HAMPSHIRE COMPREHENSIVE CANCER COLLABORATION

Goal #4 Palliation: New Hampshire residents living with cancer shall experience patient-centered cancer care that encompasses routine assessment and high quality management of physical symptoms, as well as emotional, social, and spiritual distress.

Priority Objective 14: Every New Hampshire health-care system will offer people living with cancer timely information and access to palliative care.

(A) Program Focus	(B) *Top 41* Priority Strategies	(C) Partners' Activities	(D) Outputs/Products	(E) Short-term Outcomes (1–3 years)	(F) Intermediate Outcomes (4-6 years)	(G) Performance Measure	(H) Baseline/2010 Indicators	(I) Data Source	(J) Partner Organizations
Surveillance	14.3 Increase the number of New Hampshire hospitals and health systems with clinical palliative care services.	Conduct needs assessment and environmental scans of hospitals, senior centers, community centers, etc. Develop and offer one-day event, "Establishing Palliative Care in Your Institution."	A palliative care team established within each hospital (health care institution) Total number of presentations Number of participants	Increased willingness to develop a team	Increase in the number of palliative care team Timely information and access to palliative care for NH residents	Percent of NH hospitals and health care institutions offering palliative care services Percent of NH residents that spend their last days at home.	Baseline (1991): xx % 2010: xx% Baseline (1991): 34.9 % 2010: 54.9%	Palliative Care Survey Hospital data?? Cancer registry ???	NHCCC,
Provider Education and Support	14.5 Provide education and support to New Hampshire hospitals to develop clinical Palliative Care programs, consisting of a minimum of two designated individuals from different clinical disciplines (such as a physician and nurse) responsible for dissemination of information and resources on palliative care.	Assess need. Build relationships. Provide technical assistance and support to hospitals.	Total number of TA sessions/ presentations Number of participants	Increased awareness among hospital policymakers about how to establish a clinical Palliative Care program	Increased organizational commitment to developing the services (e.g., appointment of staff to champion it within the organization, allocation of resources)				NHCCC, Hospital Association,
Provider Education and Support	14.8 Provide a variety of education programs and formats enabling clinicians caring for persons living with cancer to acquire basic information and skills in the principles of palliative and hospice care.	Assess need. Re-allocate existing resources. Advocate for new resources.	A variety of education programs and formats Number and type of programs provided.	Change in clinicians' KAB about the principles of palliative and hospice care	Clinicians' increased skills related to the principles of palliative and hospice care				

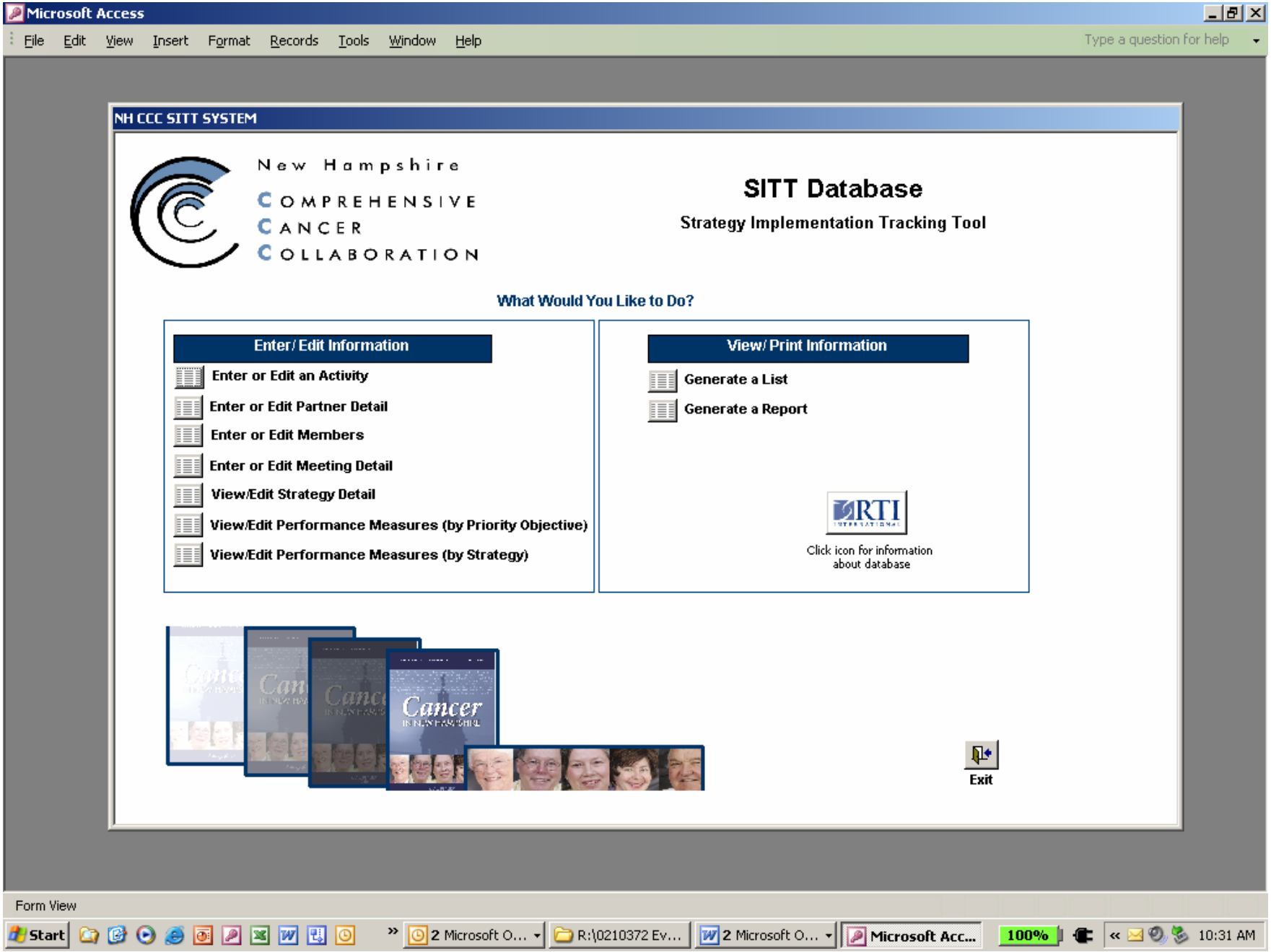
EVALUATION PLANNING MATRIX - NEW HAMPSHIRE COMPREHENSIVE CANCER COLLABORATION

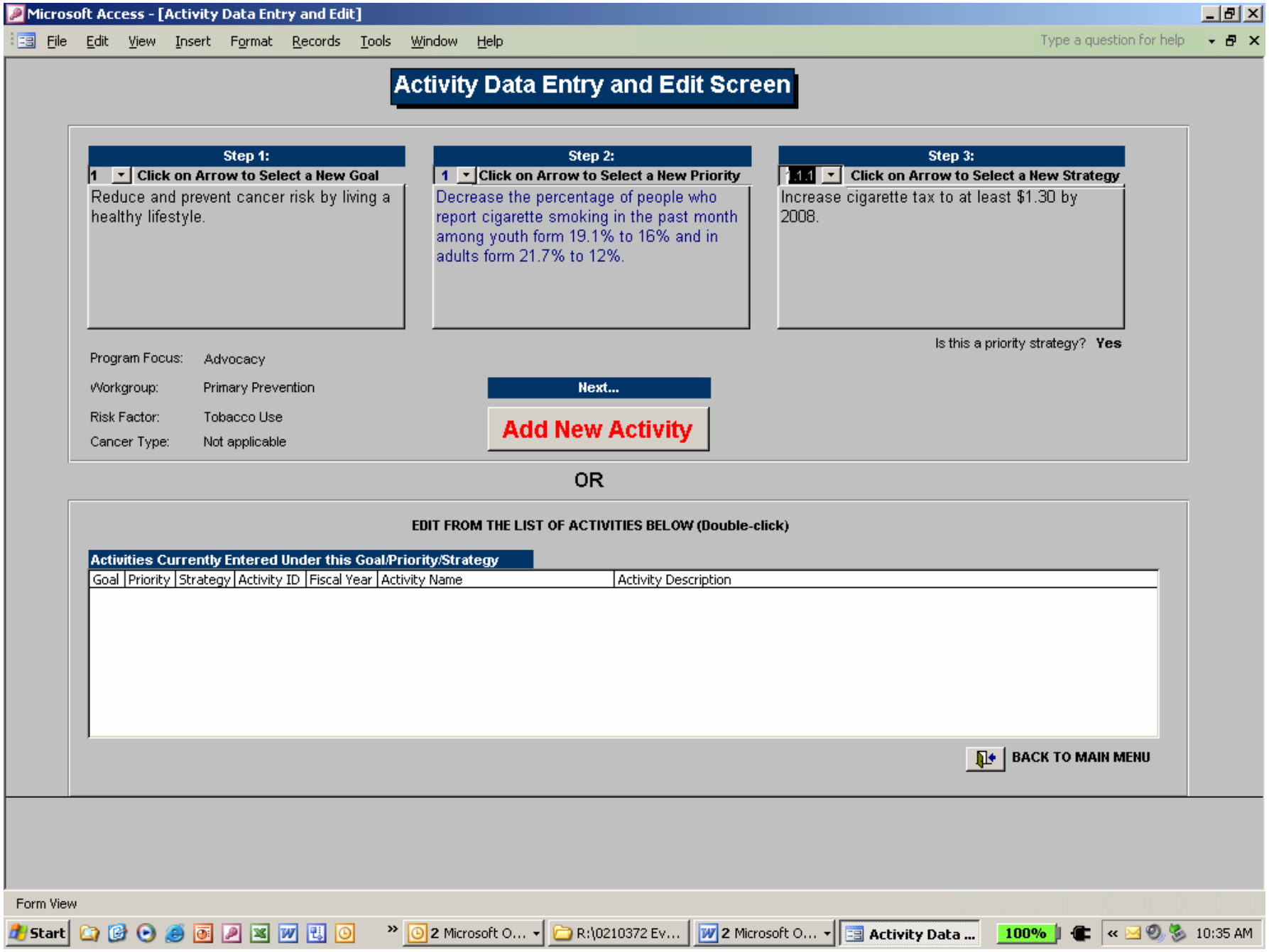
Goal #4 Palliation: New Hampshire residents living with cancer shall experience patient-centered cancer care that encompasses routine assessment and high quality management of physical symptoms, as well as emotional, social, and spiritual distress.									
Priority Objective 15: All persons living with cancer shall have effective management of pain and other symptoms.									
(A) Program Focus	**(B) *Top 41* Priority Strategies**	**(C) Partners' Activities**	**(D) Outputs/Products**	**(E) Short-term Outcomes (1–3 years)**	**(F) Intermediate Outcomes (4-6 years)**	**(G) Performance Measure**	**(H) Baseline/2010 Indicators**	**(I) Data Source**	**(J) Organizational Partner**
Provider Education and Support	15.2 Ensure all providers caring for persons living with cancer have current evidence-based information on symptom management.	Conduct a needs assessment. Promote best practices through the most effective channels for the various providers. Monitor progress.	Best practices and evidence-based information on pain and symptom management available to health care providers	Change in clinicians' KAB about managing pain and other symptoms	Increased adherence to best practices related to management of pan and other symptoms	Percent of persons living with cancer that receive effective management of pain and other symptoms	Baseline (2007): xx% 2010: xx%		NHCCC

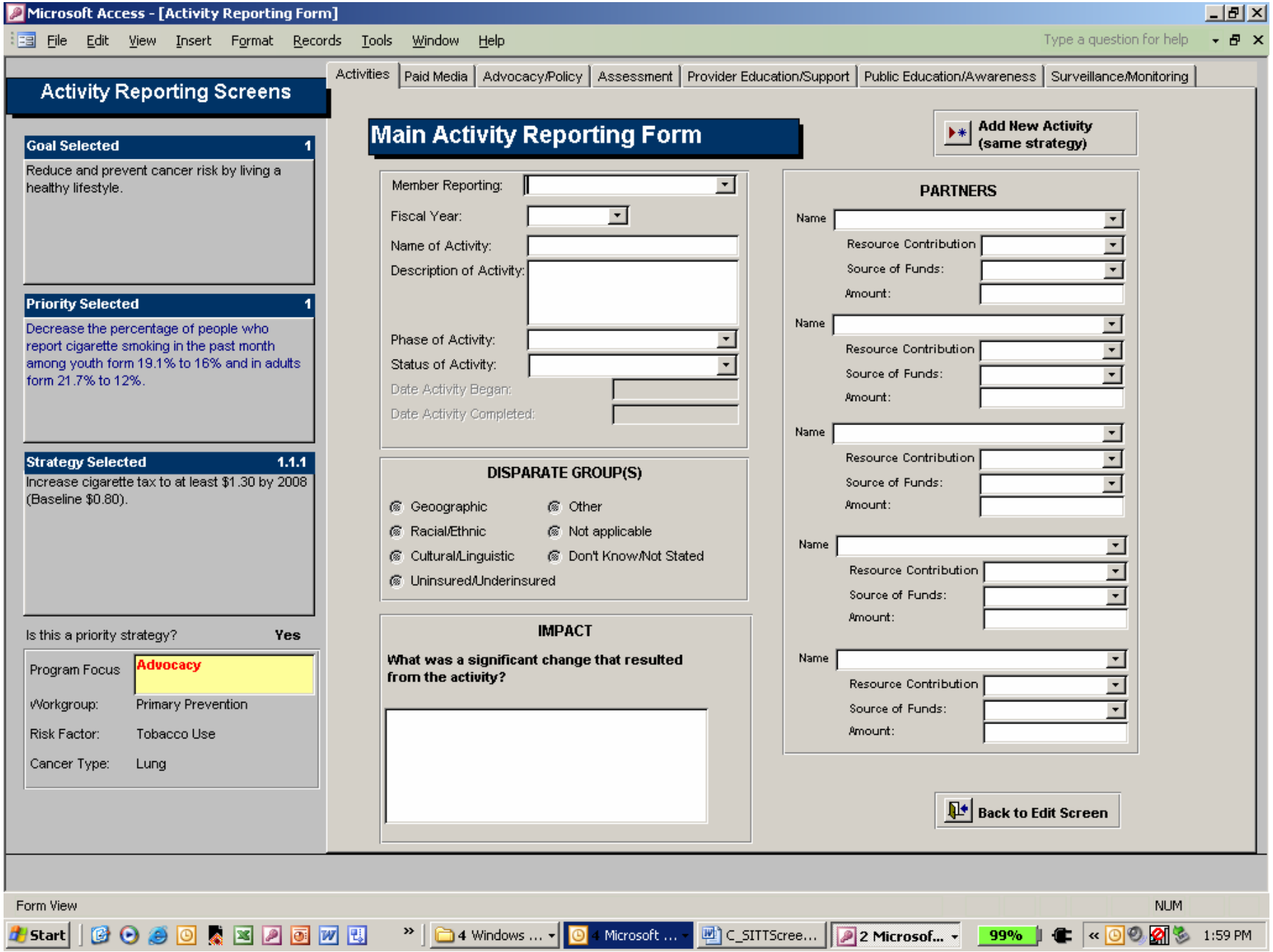
EVALUATION PLANNING MATRIX - NEW HAMPSHIRE COMPREHENSIVE CANCER COLLABORATION

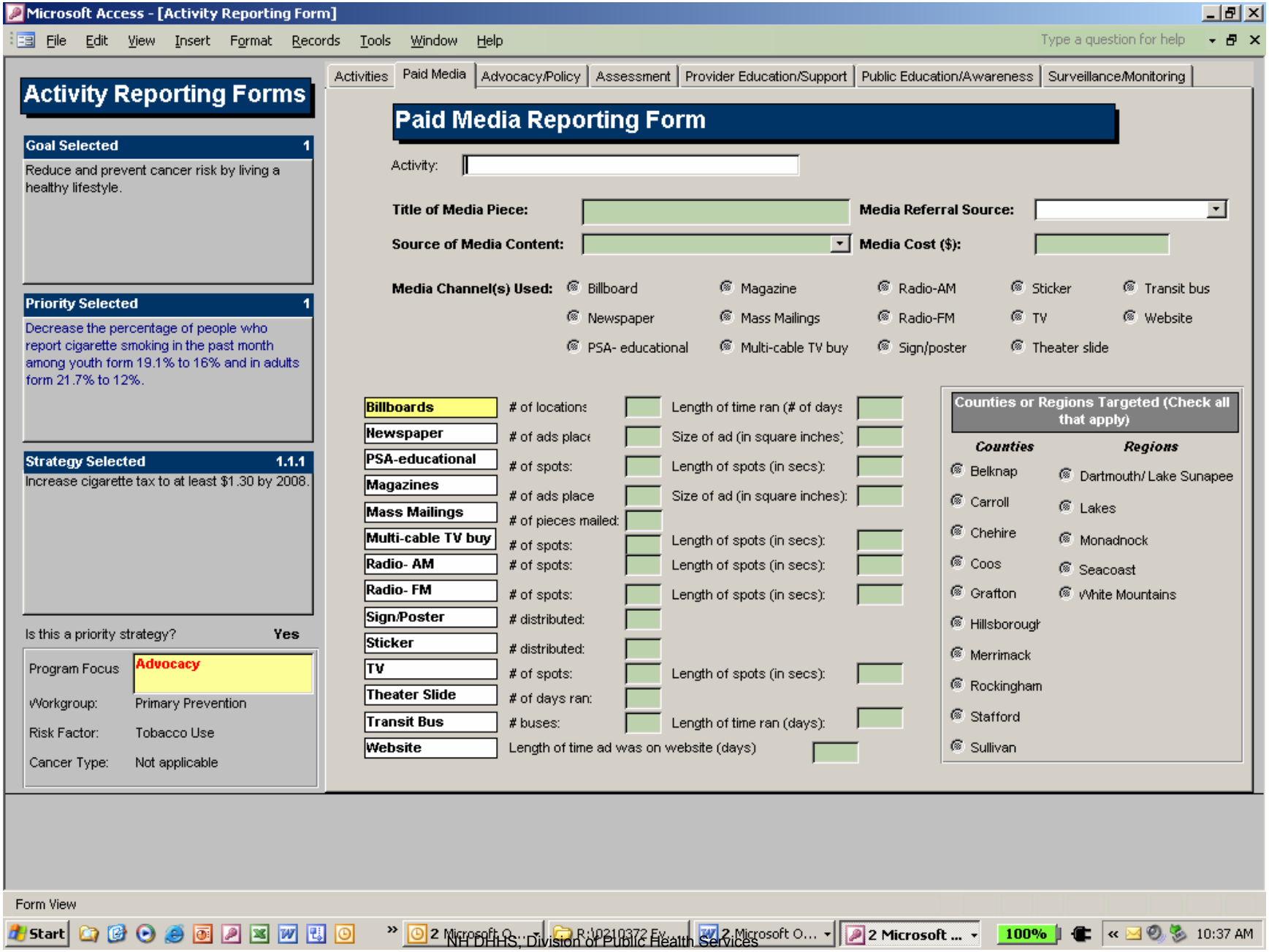
Goal #5 Emerging Issues: Identify emerging issues and develop an action plan to benefit New Hampshire residents.									
Priority Objective 16: Increase public and provider awareness regarding emerging issues in New Hampshire.									
(A) Program Focus	**(B) *Top 41* Priority Strategies**	**(C) Partners' Activities**	**(D) Outputs/Products**	**(E) Short-term Outcomes (1–3 years)**	**(F) Intermediate Outcomes (4-6 years)**	**(G) Performance Measure**	**(H) Baseline/2010 Indicators**	**(I) Data Source**	**(J) Partner Organizations**
Assessment	16.1 Identify and promote existing national and local resources that contain evidence-based research information for providers and the public.	Review current literature. Identify existing local and national resources that contain evidence-based information for providers and the public. Develop process for information exchange between the NHCCC Workgroups. Create a Web page or Web site to highlight and promote awareness of the emerging issues in cancer research with links to evidence on NCI and CDC Web sites.	Written Report Action Plan Media releases Web site Annual Emerging Issues Conference	Increased provider and public awareness of emerging issues in New Hampshire	Increased benefit from translating emerging science and technology across the cancer continuum into practice (e.g., policy and system changes)			Current research and literature NCI CDC	NHCCC Workgroups, Board, Social Marketing Specialist
Disparate populations	16.2 Eliminate disparities and barriers to cancer primary prevention, prevention and early detection, treatment and survivorship, and palliative care.								

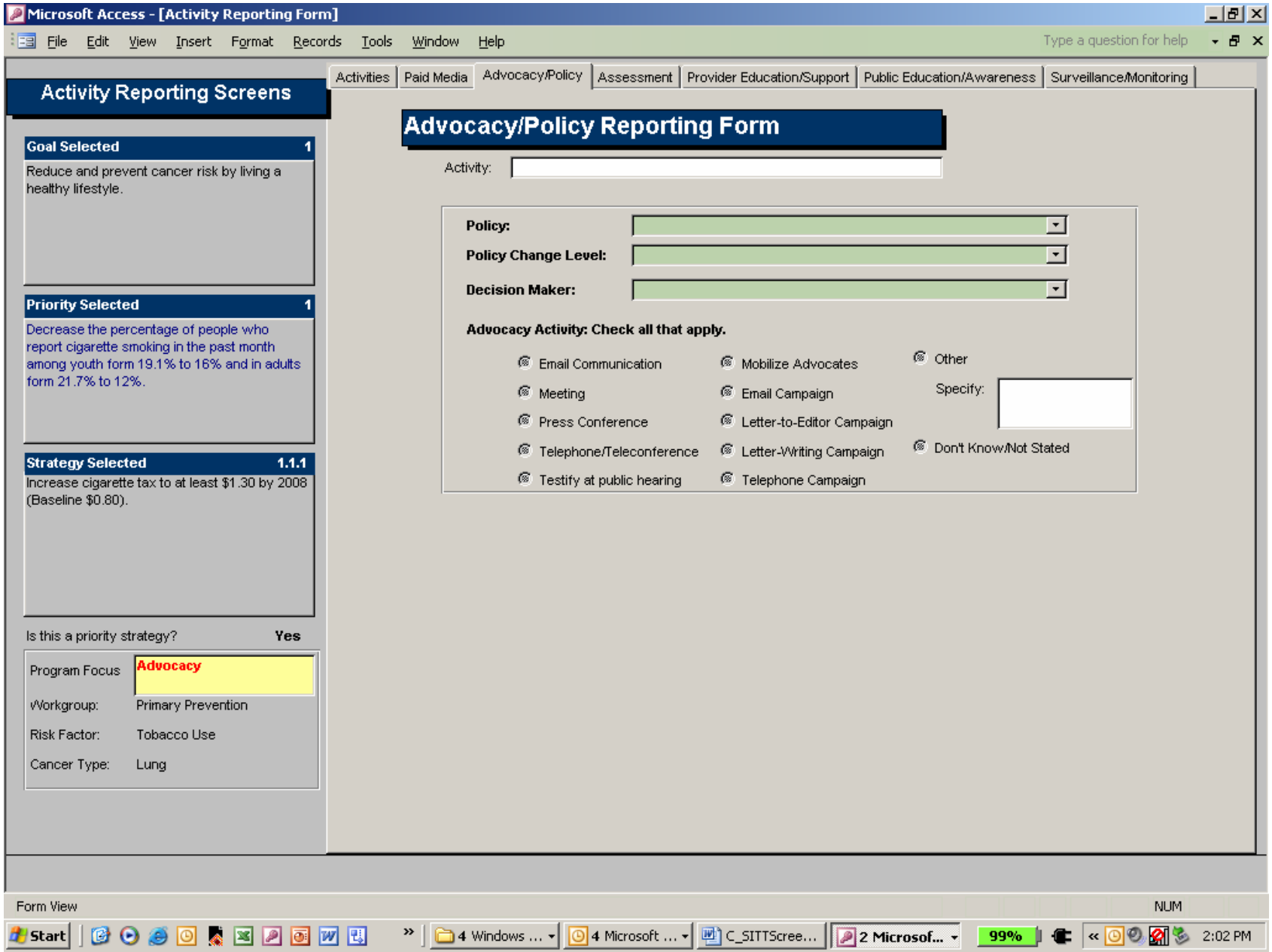
APPENDIX C:
SITT DATABASE

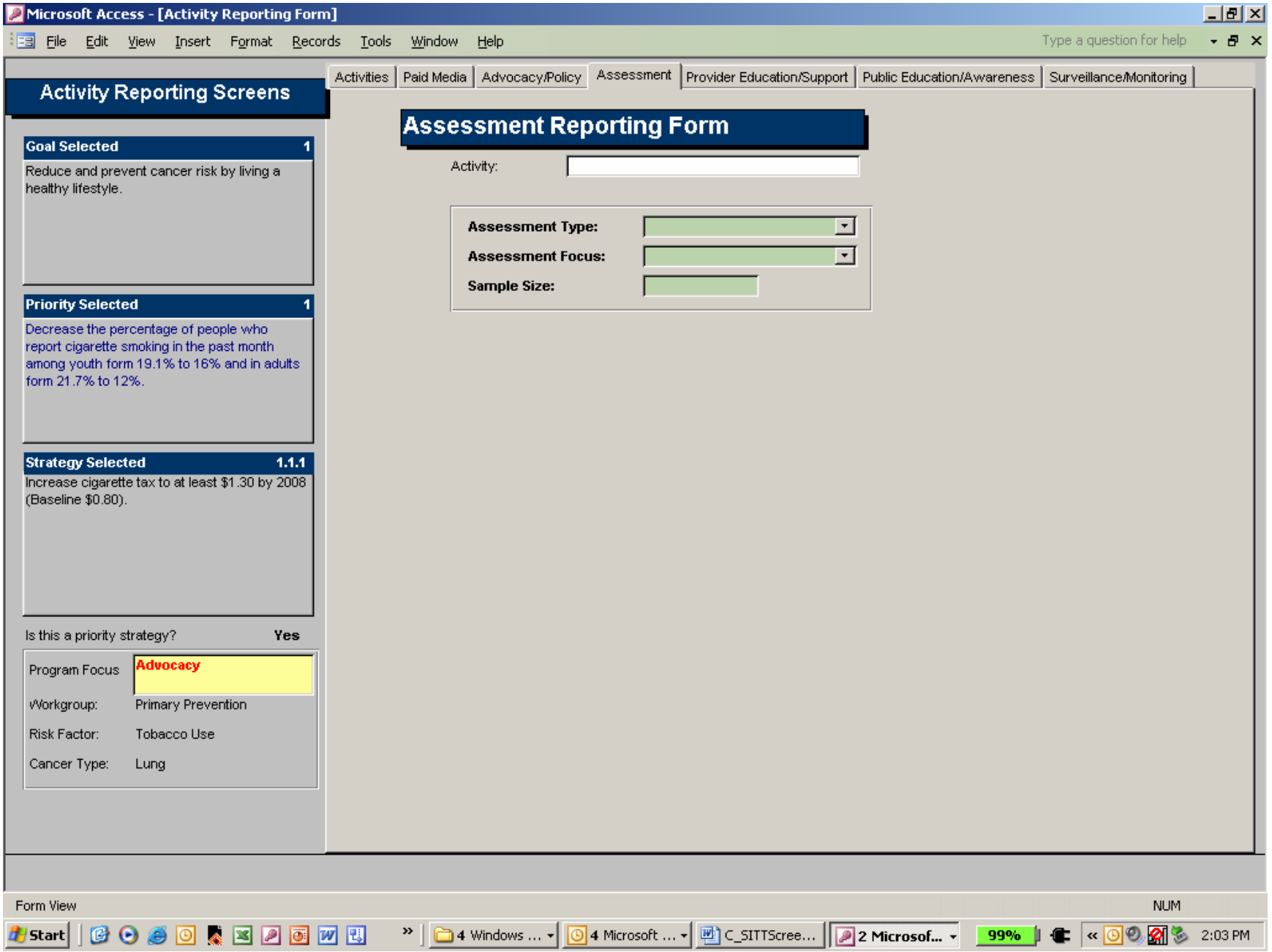

Microsoft Access
File Edit View Insert Format Records Tools Window Help
Type a question for help
NH CCC SITT SYSTEM
New Hampshire
COMPREHENSIVE
CANCER
COLLABORATION
SITT Database
Strategy Implementation Tracking Tool
What Would You Like to Do?
Enter/ Edit Information
Enter or Edit an Activity
Enter or Edit Partner Detail
Enter or Edit Members
Enter or Edit Meeting Detail
View/Edit Strategy Detail
View/Edit Performance Measures (by Priority Objective)
View/Edit Performance Measures (by Strategy)
View/ Print Information
Generate a List
Generate a Report
RTI
Click icon for information about database
Cancer
Exit
Form View
Start
2 Microsoft O...
R:\0210372 Ev...
2 Microsoft O...
Microsoft Acc...
100%
10:31 AM

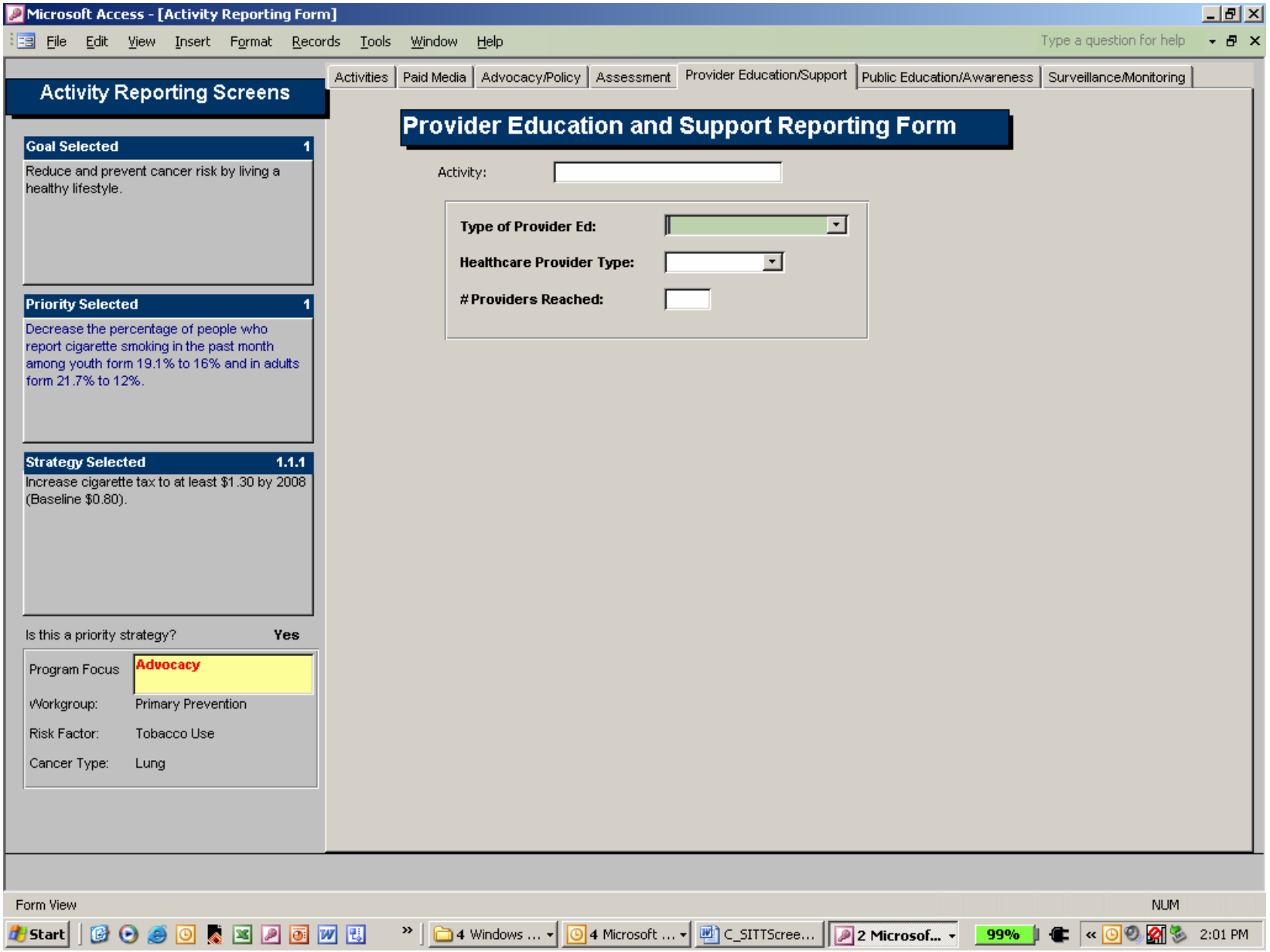

Microsoft Access - [Activity Data Entry and Edit]
File Edit View Insert Format Records Tools Window Help
Type a question for help
Activity Data Entry and Edit Screen
Step 1:
1 Click on Arrow to Select a New Goal
Reduce and prevent cancer risk by living a healthy lifestyle.
Step 2:
1 Click on Arrow to Select a New Priority
Decrease the percentage of people who report cigarette smoking in the past month among youth form 19.1% to 16% and in adults form 21.7% to 12%.
Step 3:
1.1.1 Click on Arrow to Select a New Strategy
Increase cigarette tax to at least $1.30 by 2008.
Is this a priority strategy? Yes
Program Focus: Advocacy
Workgroup: Primary Prevention
Risk Factor: Tobacco Use
Cancer Type: Not applicable
Next...
Add New Activity
OR
EDIT FROM THE LIST OF ACTIVITIES BELOW (Double-click)
Activities Currently Entered Under this Goal/Priority/Strategy
Goal
Priority
Strategy
Activity ID
Fiscal Year
Activity Name
Activity Description
BACK TO MAIN MENU
Form View
Start
2 Microsoft O...
R:\0210372 Ev...
2 Microsoft O...
Activity Data ...
100%
10:35 AM

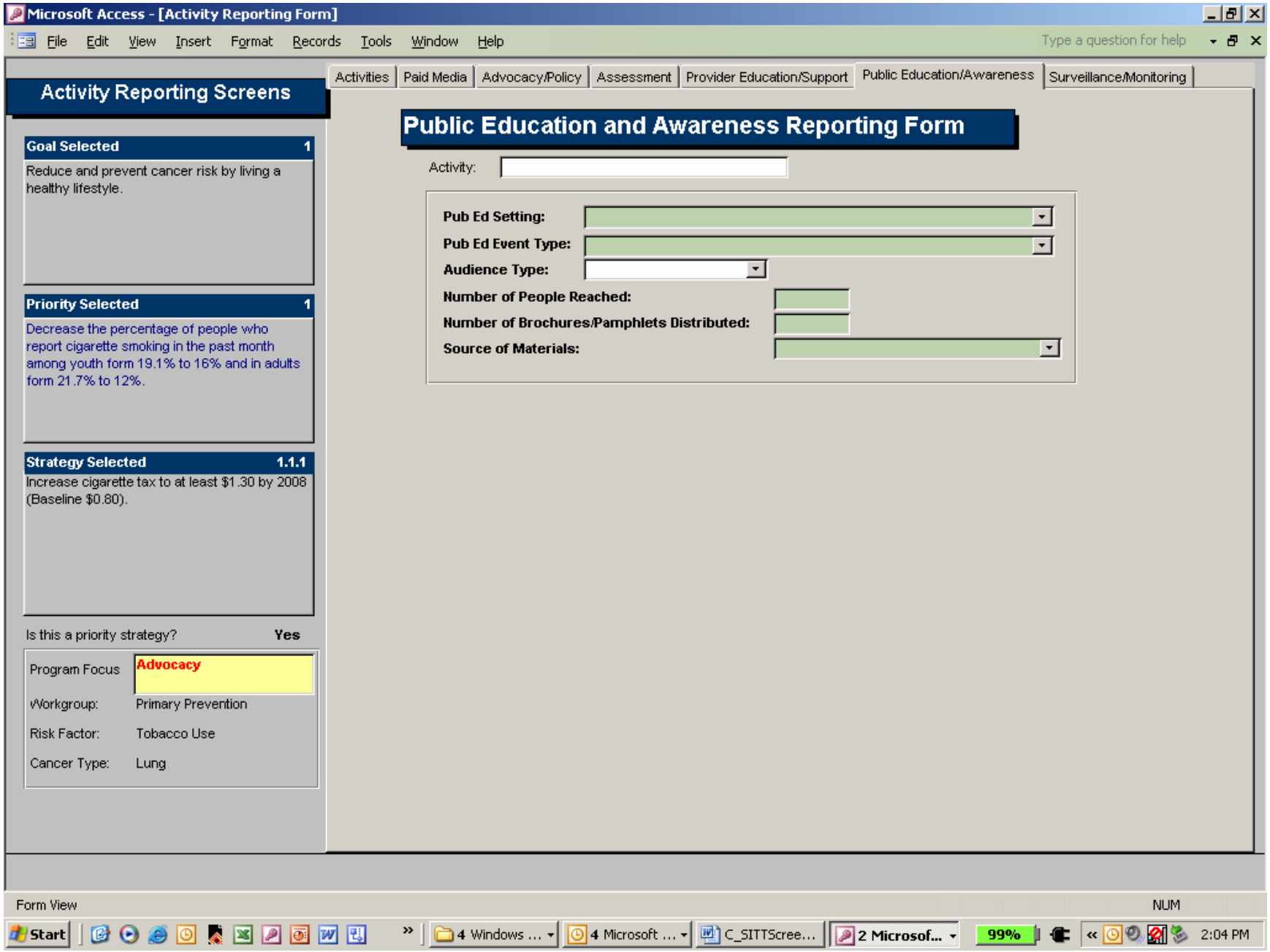

Microsoft Access - [Activity Reporting Form]
File Edit View Insert Format Records Tools Window Help
Type a question for help
Activity Reporting Screens
Activities
Paid Media
Advocacy/Policy
Assessment
Provider Education/Support
Public Education/Awareness
Surveillance/Monitoring
Goal Selected 1
Reduce and prevent cancer risk by living a healthy lifestyle.
Priority Selected 1
Decrease the percentage of people who report cigarette smoking in the past month among youth form 19.1% to 16% and in adults form 21.7% to 12%.
Strategy Selected 1.1.1
Increase cigarette tax to at least $1.30 by 2008 (Baseline $0.80).
Is this a priority strategy? Yes
Program Focus Advocacy
Workgroup: Primary Prevention
Risk Factor: Tobacco Use
Cancer Type: Lung
Main Activity Reporting Form
Add New Activity (same strategy)
Member Reporting:
Fiscal Year:
Name of Activity:
Description of Activity:
Phase of Activity:
Status of Activity:
Date Activity Began:
Date Activity Completed:
DISPARATE GROUP(S)
Geoographic
Racial/Ethnic
Cultural/Linguistic
Uninsured/Underinsured
Other
Not applicable
Don't Know/Not Stated
IMPACT
What was a significant change that resulted from the activity?
PARTNERS
Name
Resource Contribution
Source of Funds:
Amount:
Back to Edit Screen
Form View
NUM
Start
4 Windows ...
Microsoft ...
C_SITTScree...
2 Microsof...
99%
1:59 PM

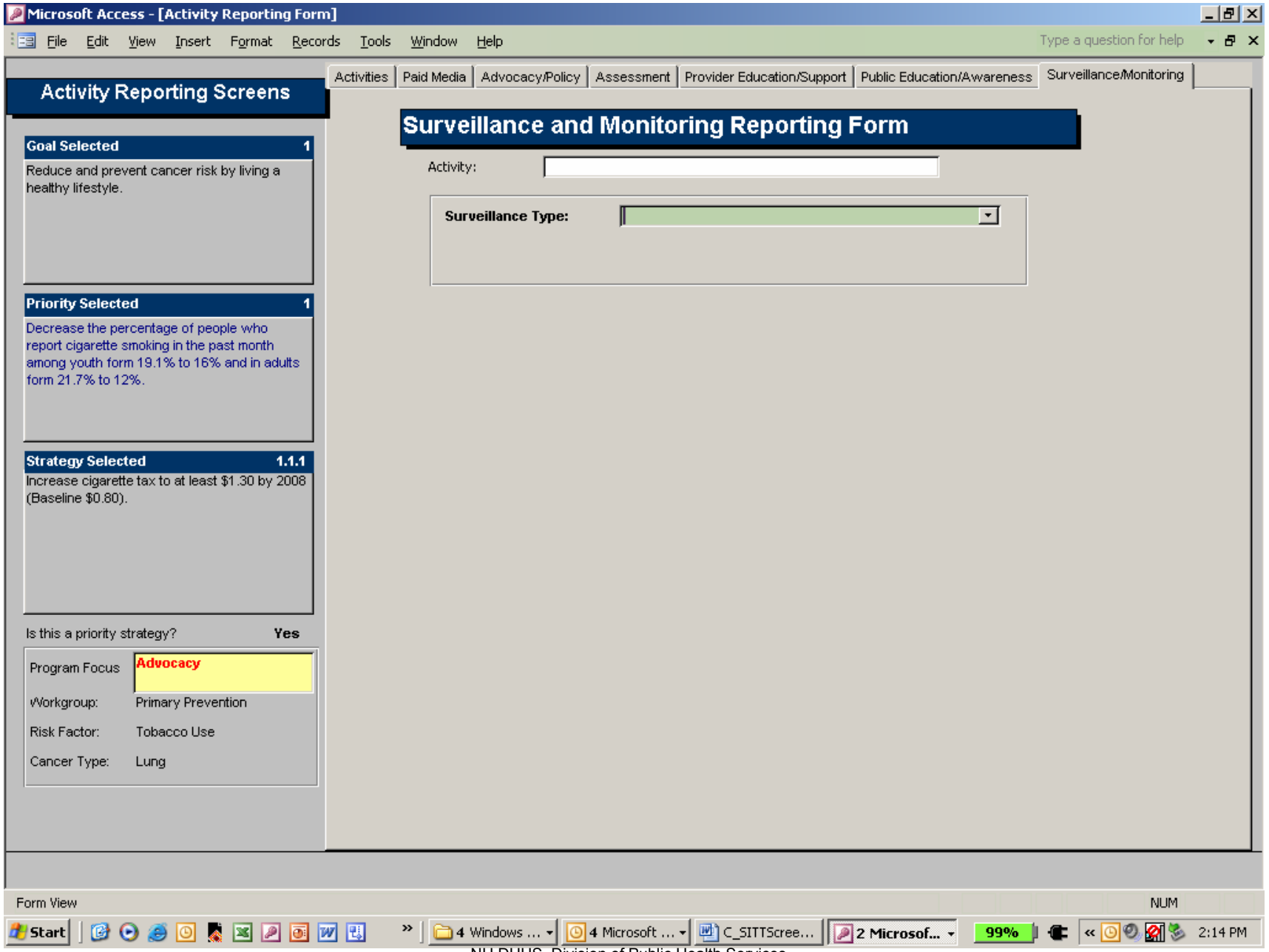

Microsoft Access - [Activity Reporting Form]
File Edit View Insert Format Records Tools Window Help
Type a question for help
Activity Reporting Forms
Goal Selected 1
Reduce and prevent cancer risk by living a healthy lifestyle.
Priority Selected 1
Decrease the percentage of people who report cigarette smoking in the past month among youth form 19.1% to 16% and in adults form 21.7% to 12%.
Strategy Selected 1.1.1
Increase cigarette tax to at least $1.30 by 2008.
Is this a priority strategy? Yes
Program Focus Advocacy
Workgroup: Primary Prevention
Risk Factor: Tobacco Use
Cancer Type: Not applicable
Activities Paid Media Advocacy/Policy Assessment Provider Education/Support Public Education/Awareness Surveillance/Monitoring
Paid Media Reporting Form
Activity:
Title of Media Piece:
Media Referral Source:
Source of Media Content:
Media Cost ($):
Media Channel(s) Used:
Billboard Magazine Radio-AM Sticker Transit bus
Newspaper Mass Mailings Radio-FM TV Website
PSA- educational Multi-cable TV buy Sign/poster Theater slide
Billboards # of locations: Length of time ran (# of days
Newspaper # of ads place Size of ad (in square inches)
PSA-educational # of spots: Length of spots (in secs):
Magazines # of ads place Size of ad (in square inches):
Mass Mailings # of pieces mailed:
Multi-cable TV buy # of spots: Length of spots (in secs):
Radio- AM # of spots: Length of spots (in secs):
Radio- FM # of spots: Length of spots (in secs):
Sign/Poster # distributed:
Sticker # distributed:
TV # of spots: Length of spots (in secs):
Theater Slide # of days ran:
Transit Bus # buses: Length of time ran (days):
Website Length of time ad was on website (days)
Counties or Regions Targeted (Check all that apply)
Counties
Belknap
Carroll
Cheshire
Coos
Grafton
Hillsborough
Merrimack
Rockingham
Stafford
Sullivan
Regions
Dartmouth/ Lake Sunapee
Lakes
Monadnock
Seacoast
White Mountains
Form View
Start
100%
10:37 AM

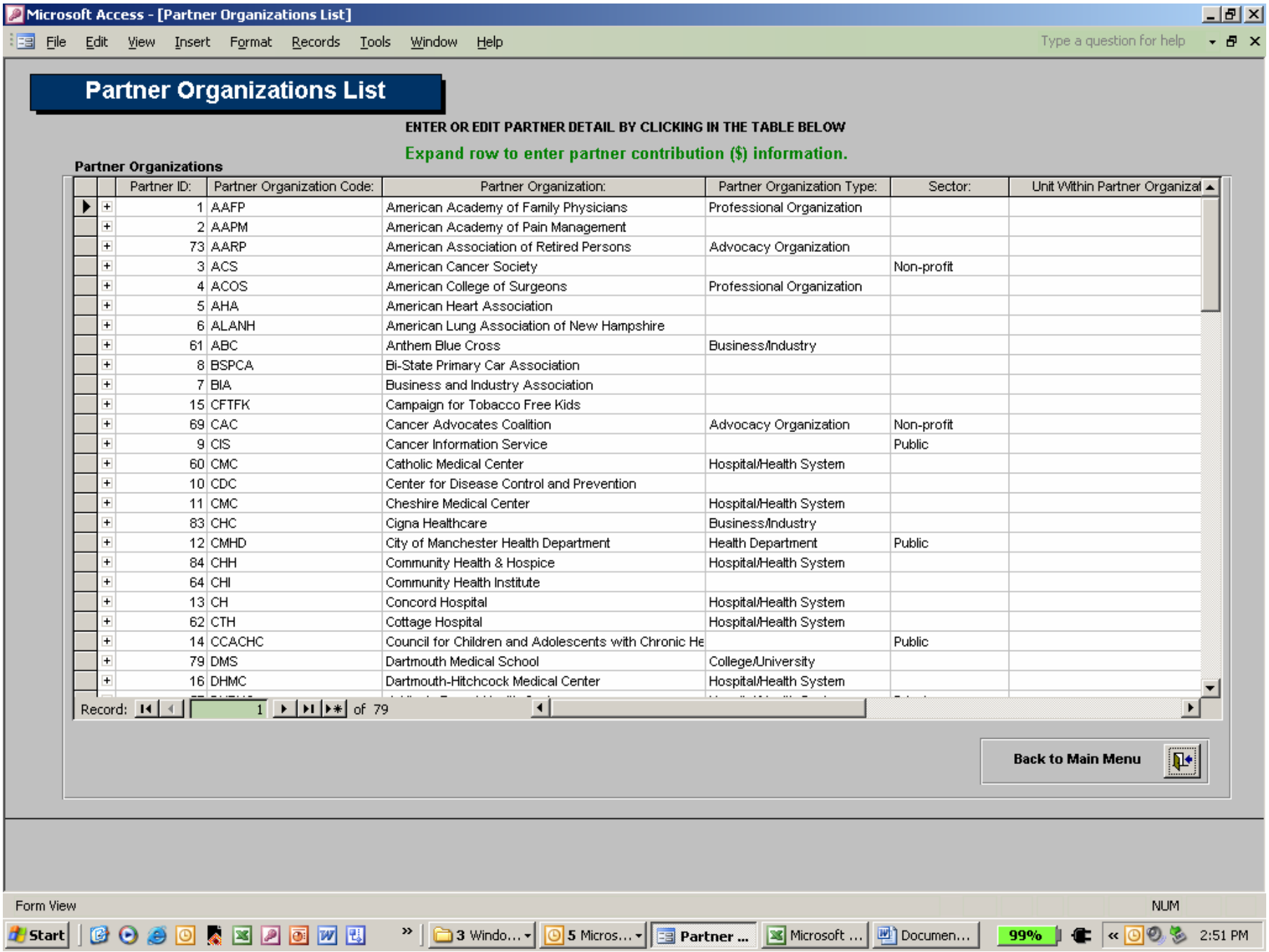

Microsoft Access - [Activity Reporting Form]
File Edit View Insert Format Records Tools Window Help
Type a question for help
Activity Reporting Screens
Activities
Paid Media
Advocacy/Policy
Assessment
Provider Education/Support
Public Education/Awareness
Surveillance/Monitoring
Goal Selected 1
Reduce and prevent cancer risk by living a healthy lifestyle.
Priority Selected 1
Decrease the percentage of people who report cigarette smoking in the past month among youth form 19.1% to 16% and in adults form 21.7% to 12%.
Strategy Selected 1.1.1
Increase cigarette tax to at least $1.30 by 2008 (Baseline $0.80).
Is this a priority strategy? Yes
Program Focus Advocacy
Workgroup: Primary Prevention
Risk Factor: Tobacco Use
Cancer Type: Lung
Advocacy/Policy Reporting Form
Activity:
Policy:
Policy Change Level:
Decision Maker:
Advocacy Activity: Check all that apply.
Email Communication
Meeting
Press Conference
Telephone/Teleconference
Testify at public hearing
Mobilize Advocates
Email Campaign
Letter-to-Editor Campaign
Letter-Writing Campaign
Telephone Campaign
Other
Specify:
Don't Know/Not Stated
Form View
NUM
Start
4 Windows ...
4 Microsoft ...
C_SITTScree...
2 Microsof...
99%
2:02 PM

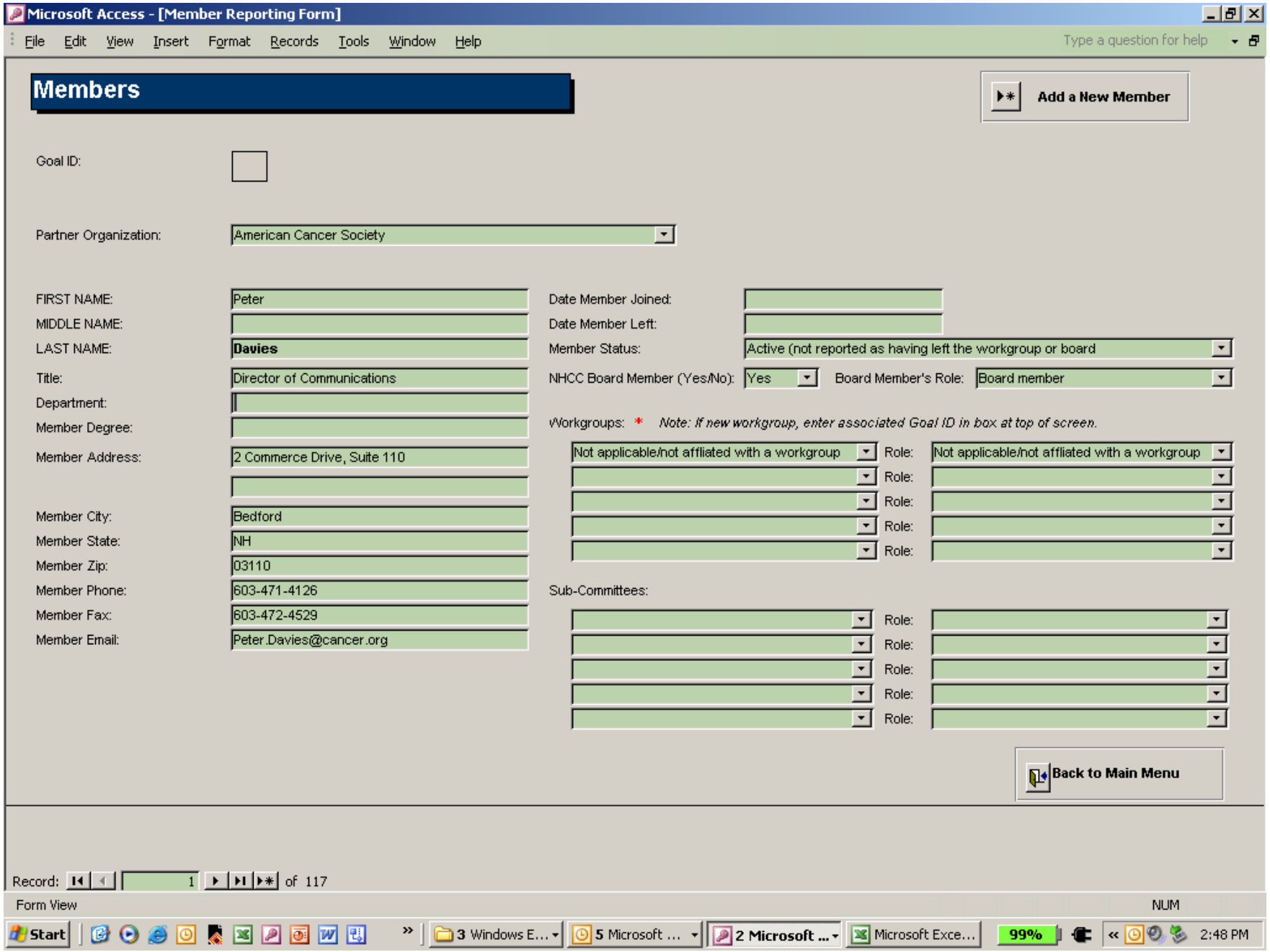

Microsoft Access - [Activity Reporting Form]
File Edit View Insert Format Records Tools Window Help
Type a question for help
Activity Reporting Screens
Activities
Paid Media
Advocacy/Policy
Assessment
Provider Education/Support
Public Education/Awareness
Surveillance/Monitoring
Goal Selected 1
Reduce and prevent cancer risk by living a healthy lifestyle.
Priority Selected 1
Decrease the percentage of people who report cigarette smoking in the past month among youth form 19.1% to 16% and in adults form 21.7% to 12%.
Strategy Selected 1.1.1
Increase cigarette tax to at least $1.30 by 2008 (Baseline $0.80).
Is this a priority strategy? Yes
Program Focus Advocacy
Workgroup: Primary Prevention
Risk Factor: Tobacco Use
Cancer Type: Lung
Assessment Reporting Form
Activity:
Assessment Type:
Assessment Focus:
Sample Size:
Form View
NUM
Start
4 Windows ...
4 Microsoft ...
C_SITTScree...
2 Microsof...
99%
2:03 PM

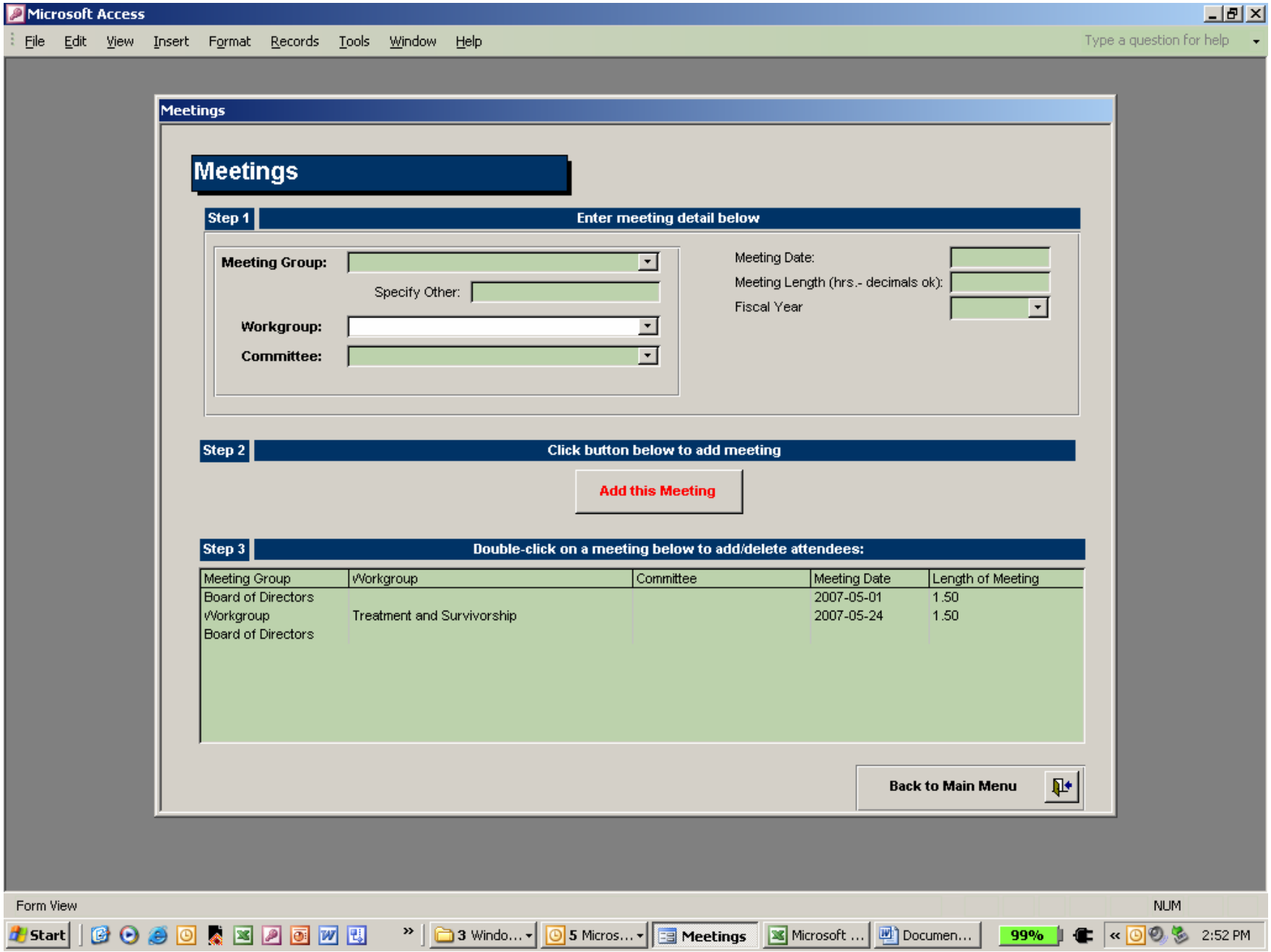

Microsoft Access - [Activity Reporting Form]
File Edit View Insert Format Records Tools Window Help
Type a question for help
Activity Reporting Screens
Goal Selected 1
Reduce and prevent cancer risk by living a healthy lifestyle.
Priority Selected 1
Decrease the percentage of people who report cigarette smoking in the past month among youth form 19.1% to 16% and in adults form 21.7% to 12%.
Strategy Selected 1.1.1
Increase cigarette tax to at least $1.30 by 2008 (Baseline $0.80).
Is this a priority strategy? Yes
Program Focus Advocacy
Workgroup: Primary Prevention
Risk Factor: Tobacco Use
Cancer Type: Lung
Activities
Paid Media
Advocacy/Policy
Assessment
Provider Education/Support
Public Education/Awareness
Surveillance/Monitoring
Provider Education and Support Reporting Form
Activity:
Type of Provider Ed:
Healthcare Provider Type:
Providers Reached:
Form View
NUM
Start
4 Windows ...
4 Microsoft ...
C_SITTScree...
2 Microsof...
99%
2:01 PM

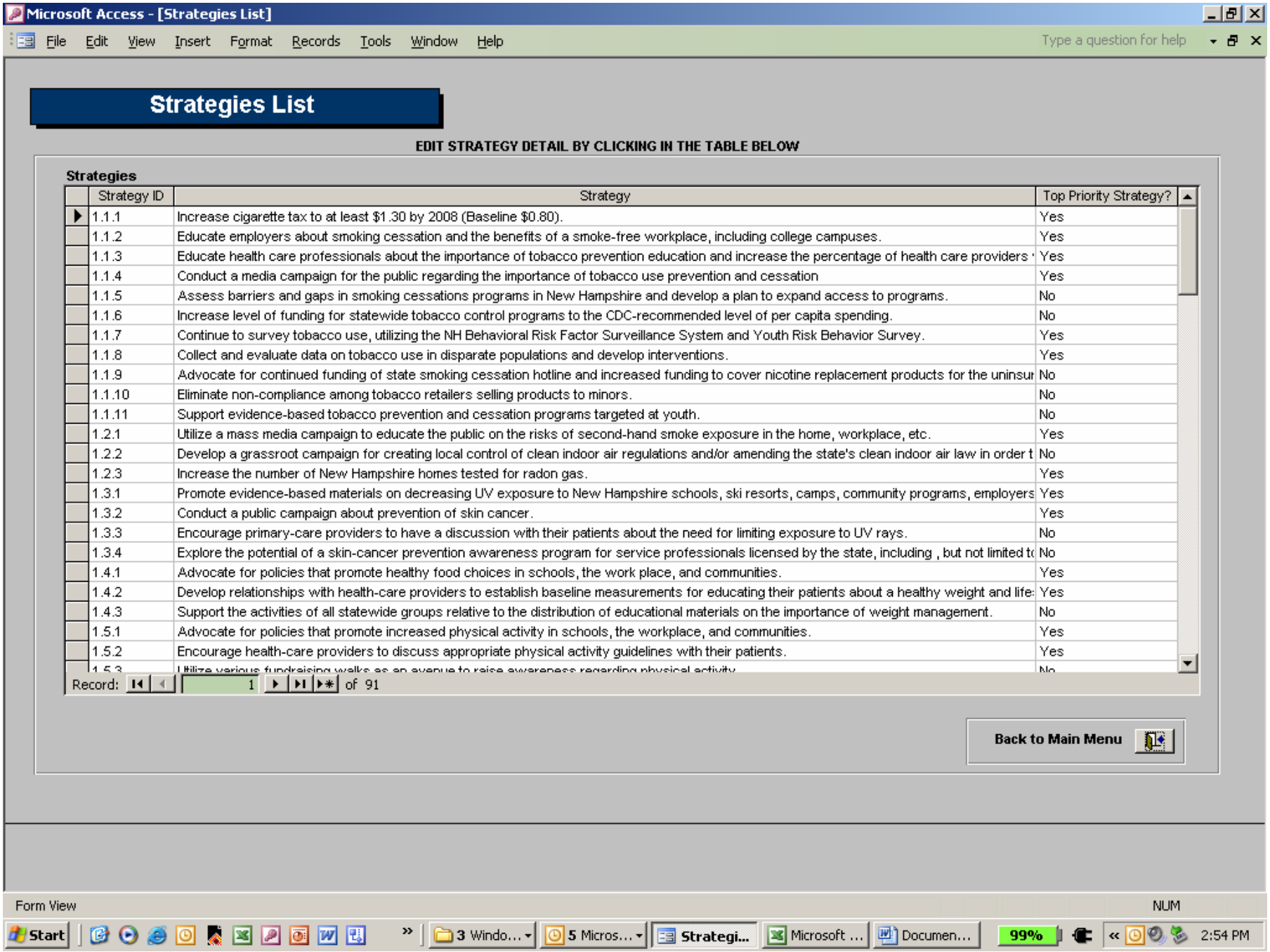

Microsoft Access - [Activity Reporting Form]
File Edit View Insert Format Records Tools Window Help
Type a question for help
Activity Reporting Screens
Goal Selected 1
Reduce and prevent cancer risk by living a healthy lifestyle.
Priority Selected 1
Decrease the percentage of people who report cigarette smoking in the past month among youth form 19.1% to 16% and in adults form 21.7% to 12%.
Strategy Selected 1.1.1
Increase cigarette tax to at least $1.30 by 2008 (Baseline $0.80).
Is this a priority strategy? Yes
Program Focus Advocacy
Workgroup: Primary Prevention
Risk Factor: Tobacco Use
Cancer Type: Lung
Activities
Paid Media
Advocacy/Policy
Assessment
Provider Education/Support
Public Education/Awareness
Surveillance/Monitoring
Public Education and Awareness Reporting Form
Activity:
Pub Ed Setting:
Pub Ed Event Type:
Audience Type:
Number of People Reached:
Number of Brochures/Pamphlets Distributed:
Source of Materials:
Form View
NUM
Start
4 Windows ...
4 Microsoft ...
C_SITTScree...
2 Microsof...
99%
2:04 PM

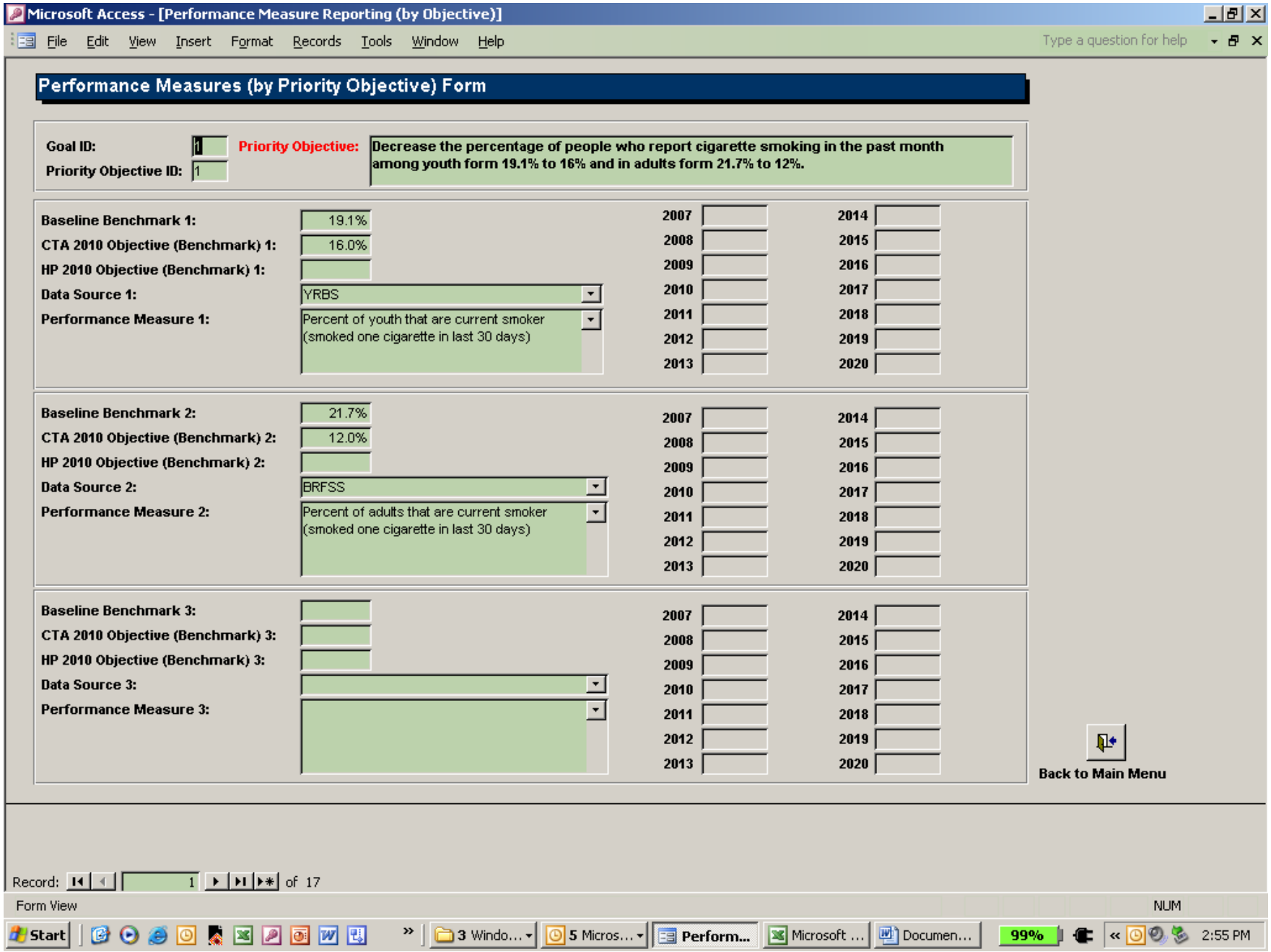

Microsoft Access - [Activity Reporting Form]
File Edit View Insert Format Records Tools Window Help
Type a question for help
Activity Reporting Screens
Activities
Paid Media
Advocacy/Policy
Assessment
Provider Education/Support
Public Education/Awareness
Surveillance/Monitoring
Goal Selected 1
Reduce and prevent cancer risk by living a healthy lifestyle.
Priority Selected 1
Decrease the percentage of people who report cigarette smoking in the past month among youth form 19.1% to 16% and in adults form 21.7% to 12%.
Strategy Selected 1.1.1
Increase cigarette tax to at least $1.30 by 2008 (Baseline $0.80).
Is this a priority strategy? Yes
Program Focus Advocacy
Workgroup: Primary Prevention
Risk Factor: Tobacco Use
Cancer Type: Lung
Surveillance and Monitoring Reporting Form
Activity:
Surveillance Type:
Form View
NUM
Start
4 Windows ...
4 Microsoft ...
C_SITTScree...
2 Microsof...
99%
2:14 PM

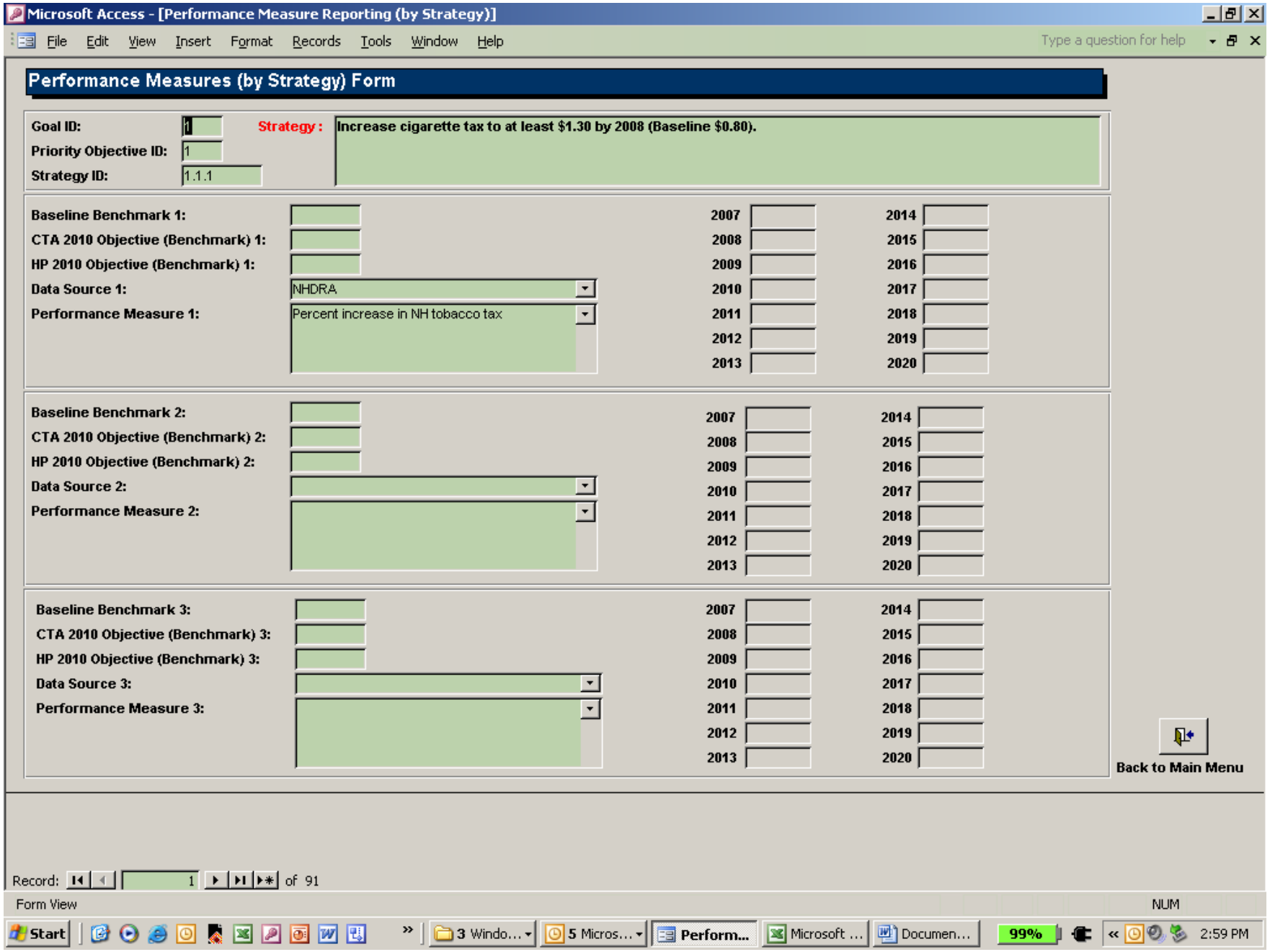

Microsoft Access - [Partner Organizations List]
File Edit View Insert Format Records Tools Window Help
Type a question for help
Partner Organizations List
ENTER OR EDIT PARTNER DETAIL BY CLICKING IN THE TABLE BELOW
Expand row to enter partner contribution ($) information.
Partner Organizations
Partner ID: | Partner Organization Code: | Partner Organization: | Partner Organization Type: | Sector: | Unit Within Partner Organizat
1 AAFP American Academy of Family Physicians Professional Organization
2 AAPM American Academy of Pain Management
73 AARP American Association of Retired Persons Advocacy Organization
3 ACS American Cancer Society Non-profit
4 ACOS American College of Surgeons Professional Organization
5 AHA American Heart Association
6 ALANH American Lung Association of New Hampshire
61 ABC Anthem Blue Cross Business/Industry
8 BSPCA Bi-State Primary Car Association
7 BIA Business and Industry Association
15 CFTFK Campaign for Tobacco Free Kids
69 CAC Cancer Advocates Coalition Advocacy Organization Non-profit
9 CIS Cancer Information Service Public
60 CMC Catholic Medical Center Hospital/Health System
10 CDC Center for Disease Control and Prevention
11 CMC Cheshire Medical Center Hospital/Health System
83 CHC Cigna Healthcare Business/Industry
12 CMHD City of Manchester Health Department Health Department Public
84 CHH Community Health & Hospice Hospital/Health System
64 CHI Community Health Institute
13 CH Concord Hospital Hospital/Health System
62 CTH Cottage Hospital Hospital/Health System
14 CCACHC Council for Children and Adolescents with Chronic He Public
79 DMS Dartmouth Medical School College/University
16 DHMC Dartmouth-Hitchcock Medical Center Hospital/Health System
Record: 1 of 79
Back to Main Menu
Form View
NUM
Start
3 Windo...
5 Micros...
Partner ...
Microsoft ...
Documen...
99%
2:51 PM


Microsoft Access - [Member Reporting Form]
File Edit View Insert Format Records Tools Window Help
Type a question for help
Members
Add a New Member
Goal ID:
Partner Organization:
American Cancer Society
FIRST NAME:
Peter
MIDDLE NAME:
LAST NAME:
Davies
Title:
Director of Communications
Department:
Member Degree:
Member Address:
2 Commerce Drive, Suite 110
Member City:
Bedford
Member State:
NH
Member Zip:
03110
Member Phone:
603-471-4126
Member Fax:
603-472-4529
Member Email:
Peter.Davies@cancer.org
Date Member Joined:
Date Member Left:
Member Status:
Active (not reported as having left the workgroup or board
NHCC Board Member (Yes/No):
Yes
Board Member's Role:
Board member
Workgroups: *
Note: If new workgroup, enter associated Goal ID in box at top of screen.
Not applicable/not affliated with a workgroup
Role:
Not applicable/not affliated with a workgroup
Sub-Committees:
Back to Main Menu
Record: 1 of 117
Form View
NUM
Start
3 Windows E...
5 Microsoft ...
2 Microsoft ...
Microsoft Exce...
99%
2:48 PM


Microsoft Access
File Edit View Insert Format Records Tools Window Help
Type a question for help
Meetings
Meetings
Step 1
Enter meeting detail below
Meeting Group:
Specify Other:
Workgroup:
Committee:
Meeting Date:
Meeting Length (hrs.- decimals ok):
Fiscal Year
Step 2
Click button below to add meeting
Add this Meeting
Step 3
Double-click on a meeting below to add/delete attendees:
Meeting Group
Workgroup
Committee
Meeting Date
Length of Meeting
Board of Directors
2007-05-01
1.50
Workgroup
Treatment and Survivorship
2007-05-24
1.50
Board of Directors
Back to Main Menu
Form View
NUM
Start
3 Windo...
5 Micros...
Meetings
Microsoft ...
Documen...
99%
2:52 PM


Microsoft Access - [Strategies List]
File Edit View Insert Format Records Tools Window Help
Type a question for help
Strategies List
EDIT STRATEGY DETAIL BY CLICKING IN THE TABLE BELOW
Strategies
Strategy ID | Strategy | Top Priority Strategy?
1.1.1 | Increase cigarette tax to at least $1.30 by 2008 (Baseline $0.80). | Yes
1.1.2 | Educate employers about smoking cessation and the benefits of a smoke-free workplace, including college campuses. | Yes
1.1.3 | Educate health care professionals about the importance of tobacco prevention education and increase the percentage of health care providers | Yes
1.1.4 | Conduct a media campaign for the public regarding the importance of tobacco use prevention and cessation | Yes
1.1.5 | Assess barriers and gaps in smoking cessations programs in New Hampshire and develop a plan to expand access to programs. | No
1.1.6 | Increase level of funding for statewide tobacco control programs to the CDC-recommended level of per capita spending. | No
1.1.7 | Continue to survey tobacco use, utilizing the NH Behavioral Risk Factor Surveillance System and Youth Risk Behavior Survey. | Yes
1.1.8 | Collect and evaluate data on tobacco use in disparate populations and develop interventions. | Yes
1.1.9 | Advocate for continued funding of state smoking cessation hotline and increased funding to cover nicotine replacement products for the uninsur | No
1.1.10 | Eliminate non-compliance among tobacco retailers selling products to minors. | No
1.1.11 | Support evidence-based tobacco prevention and cessation programs targeted at youth. | No
1.2.1 | Utilize a mass media campaign to educate the public on the risks of second-hand smoke exposure in the home, workplace, etc. | Yes
1.2.2 | Develop a grassroot campaign for creating local control of clean indoor air regulations and/or amending the state's clean indoor air law in order t | No
1.2.3 | Increase the number of New Hampshire homes tested for radon gas. | Yes
1.3.1 | Promote evidence-based materials on decreasing UV exposure to New Hampshire schools, ski resorts, camps, community programs, employers | Yes
1.3.2 | Conduct a public campaign about prevention of skin cancer. | Yes
1.3.3 | Encourage primary-care providers to have a discussion with their patients about the need for limiting exposure to UV rays. | No
1.3.4 | Explore the potential of a skin-cancer prevention awareness program for service professionals licensed by the state, including , but not limited t | No
1.4.1 | Advocate for policies that promote healthy food choices in schools, the work place, and communities. | Yes
1.4.2 | Develop relationships with health-care providers to establish baseline measurements for educating their patients about a healthy weight and life | Yes
1.4.3 | Support the activities of all statewide groups relative to the distribution of educational materials on the importance of weight management. | No
1.5.1 | Advocate for policies that promote increased physical activity in schools, the workplace, and communities. | Yes
1.5.2 | Encourage health-care providers to discuss appropriate physical activity guidelines with their patients. | Yes
1.5.3 | Utilize various fundraising walks as an avenue to raise awareness regarding physical activity | No
Record: 1 of 91
Back to Main Menu
Form View
NUM
Start
3 Windo...
5 Micros...
Strategi...
Microsoft ...
Documen...
99%
2:54 PM


Microsoft Access - [Performance Measure Reporting (by Objective)]
File Edit View Insert Format Records Tools Window Help
Type a question for help
Performance Measures (by Priority Objective) Form
Goal ID: 1
Priority Objective ID: 1
Priority Objective: Decrease the percentage of people who report cigarette smoking in the past month among youth form 19.1% to 16% and in adults form 21.7% to 12%.
Baseline Benchmark 1: 19.1%
CTA 2010 Objective (Benchmark) 1: 16.0%
HP 2010 Objective (Benchmark) 1:
Data Source 1: YRBS
Performance Measure 1: Percent of youth that are current smoker (smoked one cigarette in last 30 days)
Baseline Benchmark 2: 21.7%
CTA 2010 Objective (Benchmark) 2: 12.0%
HP 2010 Objective (Benchmark) 2:
Data Source 2: BRFSS
Performance Measure 2: Percent of adults that are current smoker (smoked one cigarette in last 30 days)
Baseline Benchmark 3:
CTA 2010 Objective (Benchmark) 3:
HP 2010 Objective (Benchmark) 3:
Data Source 3:
Performance Measure 3:
2007 2008 2009 2010 2011 2012 2013
2014 2015 2016 2017 2018 2019 2020
Back to Main Menu
Record: 1 of 17
Form View
NUM
Start
3 Windo...
5 Micros...
Perform...
Microsoft ...
Documen...
99%
2:55 PM


Microsoft Access - [Performance Measure Reporting (by Strategy)]
File Edit View Insert Format Records Tools Window Help
Type a question for help
Performance Measures (by Strategy) Form
Goal ID: 1
Priority Objective ID: 1
Strategy ID: 1.1.1
Strategy : Increase cigarette tax to at least $1.30 by 2008 (Baseline $0.80).
Baseline Benchmark 1:
CTA 2010 Objective (Benchmark) 1:
HP 2010 Objective (Benchmark) 1:
Data Source 1: NHDRA
Performance Measure 1: Percent increase in NH tobacco tax
2007 2008 2009 2010 2011 2012 2013
2014 2015 2016 2017 2018 2019 2020
Baseline Benchmark 2:
CTA 2010 Objective (Benchmark) 2:
HP 2010 Objective (Benchmark) 2:
Data Source 2:
Performance Measure 2:
2007 2008 2009 2010 2011 2012 2013
2014 2015 2016 2017 2018 2019 2020
Baseline Benchmark 3:
CTA 2010 Objective (Benchmark) 3:
HP 2010 Objective (Benchmark) 3:
Data Source 3:
Performance Measure 3:
2007 2008 2009 2010 2011 2012 2013
2014 2015 2016 2017 2018 2019 2020
Back to Main Menu
Record: 1 of 91
Form View
NUM
Start
3 Windo...
5 Micros...
Perform...
Microsoft ...
Documen...
99%
2:59 PM

APPENDIX D:
SITT DATA ELEMENTS

Field #	Field Name	Database Label	Command Type	Command Detail	Name of the Database Form	Evaluation Detail	Questions for NHCCC
1		Level at which policy change is sought	Drop Down Menu	<Select from drop menu> 1=Organization, 2=City/Town, 3=County, 4=State, 5=Not Applicable	*Advocacy /Policy Change Reporting Form*		
2		Type of advocacy activity (individual and campaigns)	Drop Down Menu	<Select from drop menu> 1=Email communication, 2=Meeting, 3=Press conference, 4=Telephone/Teleconference 5=Testifying at public hearing, 6=Mobilize advocates, 7=Email campaign, 8=Letter to editor campaign, 9=Letter-writing campaign, 10=Telephone campaign	*Advocacy /Policy Change Reporting Form*		
3		Type decision maker targeted	Drop Down Menu	<Select from drop menu> 1= Agency Head, 2=Agency staff, 3=Elected official, 4=Other	*Advocacy /Policy Change Reporting Form*		
4		Type of assessment	Drop Down Menu	<Select from drop menu> 1=Focus groups, 2=Interviews, 3=Inventory, 4=Survey, 5=Other	*Assessment Reporting Form*		
5		Focus of assessment	Drop Down Menu	<Select from drop menu> 1=Clinical trials, 2=Local treatment resources, 2=National treatment resources, 3=Support groups,	*Assessment Reporting Form*		
6		Sample Size			*Assessment Reporting Form*		
7	Date Activity Completed	Activity completed	Date	Enter numbers only. Automatically add the dividers. Can not be the same as "Date started."	*Main Activity Reporting Form*	On what date was the activity completed?	
8	Date Activity Started	Activity started	Date	Enter numbers only. Automatically add the dividers (/).	*Main Activity Reporting Form*	On what date was the activity started?	
9	Disparate group targeted	Disparate group targeted	Drop Down Menu	<Select from drop menu> 1=	*Main Activity Reporting Form*		
10	Goal ID	Goal	Drop Down Menu	*<Select from drop menu> A Call to Action 2010* sets forth six goals. Goal I= "Reduce and prevent cancer risk by living a healthy lifestyle;" Goal II="Reduce cancer morbidity and mortality by increasing the screening rates for those cancers where evidenced-based guidelines exist;" Goal III= "Quality treatment shall be available and accessible to all New Hampshire residents;" Goal IV= "New Hampshire residents living with cancer shall experience patient-centered cancer care that encompasses routine assessment and high quality management of physical symptoms, as well as emotional, social and spiritual distress;" Goal V= "Identify emerging issues and develop an action plan to benefit New Hampshire residents;" Goal VI= "Crucial to plan implementation will be the sustainability of the New Hampshire Comprehensive Cancer Collaboration."	*Main Activity Reporting Form*	What goal did this activity address?	
11	Partner 1 Contribution, Partner 2 Contribution, Partner 3 Contribution, Partner 4 Contribution, Partner 5 Contribution	Partner's Resource Contribution	Drop Down Menu	<Select from drop menu> 1= None; 2=Educational materials; 3= Funds; 4=In-kind resources (printing, supplies, meeting space, administrative support, staffing, etc.); 5=Other; 99=DNK/Not stated	*Main Activity Reporting Form*	What was the primary resource contributed by the partner organization to assure the implementation of this particular strategy? IF FUNDS, NEED TO ANSWER THE NEXT QUESTION.	Do you want a forced choice? That means that each partner must determine their main (or primary) contribution. Or do you want to capture more than one? How would you use this information? What report? To whom? NEED TO THINK ABOUT WHAT IS CRITICAL TO CAPTURE AND DEFINE. ONLY FUNDS??
12	Partner 1 Fund Source; Partner 2 Fund Source; Partner 3 Fund Source;	Source of funds:	Drop Down Menu	<Select from drop menu> 1=CDC 2=Federal but Non-CDC); 3=NHDHHS; 4=Non-profit organization; 5=State but Non-NHDHHS; 6=Other; 99=DNK/Not stated	*Main Activity Reporting Form*	What funds were used to support this activity? What was the original source of these funds? (For example if it is subcontract with a second party, with whom did the first party contract?	
13	Priority Objective	Priority Objective	Drop Down Menu	*<Select from drop menu> A Call to Action 2010* sets forth 17 priority objectives. THEY ARE LISTED IN THE TABLE - "Priority Objectives."	*Main Activity Reporting Form*	What priority objective did this activity address>	
14	Strategy ID	Strategy ID	Drop Down Menu	<Select from drop menu> Call to Action 2010 sets forth 91 strategies that are consecutively numbered starting with 1.1.01 through 6.17.6, linking each strategy to its goal and priority objective. The first number refers to one of the 6 goals. The second number represents one of the 17 priority objective and the third number denotes the particular strategy for that priority objective. They are listed in a separate worksheet titled "Strategies."	*Main Activity Reporting Form*		

Field #	Field Name	Database Label	Command Type	Command Detail	Name of the Database Form	Evaluation Detail	Questions for NHCCC
15	Strategy Name	Strategy Name	Drop Down Menu	*<Select from drop menu> T*hey are listed in a separate worksheet titled "Strategies." Complete text from the *A Call to Action 2010* .	*Main Activity Reporting Form*	What strategy did this activity address?	All of the strategies will be in the database; however, the database will automatically select the 39 Top Priority strategies for data entry.
16		Year		YYYY. Funding Year, start with 2006 and put in up to 2014, a total of 10 years.	*Main Activity Reporting Form*	Year in which the activity was planned, implemented, or evaluated.	NOTE: Workgroup chairs reported that some strategies have already been completed or acted upon.
17		Month		<Select from drop menu> MM 01=January, 02=February, 03=March, 04=April, 05=May, 06=June, 07=July, 08=August, 09=September, 10=October, 11=November, 12=December	*Main Activity Reporting Form*	Month in which the activity was planned, implemented, or evaluated.	
18		Quarters	Open	<Select from drop menu> (1= July–September; 2=October–December; 3= January–March; 4= April–June). CREATE USING YEAR AND MONTH DATA FIELDS.	*Main Activity Reporting Form*	In what quarter was the activity planned, implemented, or evaluated? Create quarter as a unit for summarizing and reporting the data. Data will be entered by month (the smallest unit) and aggregated for the quarter.	What is the desired frequency for updating partners' progress on each strategy? Monthly, bi-monthly, quarterly?
19		State Fiscal Year (SFY)	Drop Down Menu	YYYY. Funding Year, start with 2005 and put in up to 2014, a total of 10 years. CREATE USING YEAR AND MONTH DATA FIELDS.	*Main Activity Reporting Form*	In what fiscal year was this activity initiated and completed? Compute the fiscal year as a unit for summarizing and reporting the data. Data will be entered by month and year and aggregated for the state fiscal year (e.g., for graphs, charts).	What year do you want to start? To end? Need to be able to capture those strategies that are already completed.
20		Top 41 Priority Strategy	Drop Down Menu	<Select from drop menu> 1=Yes, 2=No. The Board and Workgroups selected **41** of the 91 strategies as the priorities on which to focus their implementation efforts.	*Main Activity Reporting Form*	Was this strategy selected as a priority by the Board and/or Workgroup?	All of the strategies will be in the database; however, it will select the 39 Top Priority strategies for data entry.
21		Program Focus	Drop Down Menu	<Select from drop menu> The categorization of the priority strategies by type according to the Board and the budget contractor. 1=Advocacy, 2=Assessment, 3= **Disparate population**s, 4=Evaluation, 5=Public education and awareness, 6=Paid media, 7=Partnership, 8=Provider education and support, 9=Surveillance and monitoring, 99=DNK/Not stated. IF 1, COMPLETE ADVOCACY FOR CHANGE FOCUS ACTIVITY FORM ; IF 2, COMPLETE PUBLIC EDUCATION AND AWARENESS FOCUS ACTIVITY FORM; IF 5, COMPLETE PAID MEDIA FOCUS ACTIVITY FORM; IF 7, COMPLETE PROVIDER EDUCATION AND SUPPORT FOCUS ACTIVITY FORM; IF 8, COMPLETE SURVEILLANCE AND MONITORING FOCUS ACTIVITY FORM.	*Main Activity Reporting Form*	What type of activity was implemented? Create a Link to FORM THAT COLLECTS DATA ELEMENTS SPECIFIC TO THAT PROGRAM FOCUS.	Are these categorizations consistent with what the contractor used in the budget proposal? INCLUDED THE 99 CODE BECAUSE ONLY THE 39 PRIORITY STRATEGIES HAVE BEEN LINKED TO A PROGRAM FOCUS.
22		Risk Factors	Drop Down Menu	<Select from drop menu> 1=Environmental Exposure; 2=Nutrition; 3=Physical Activity; 4=Radon Gas; 5=Secondhand Smoke; 6=Tobacco Use; 7 Exposure to Ultraviolet Rays; 8=Other; 99=DNK/Not stated. THIS FIELD IS COMPLETE FOR EACH STRATEGY UNDER GOAL 1 (PRIMARY PREVENTION) AND WILL AUTOMATICALLY APPEAR WHEN ONE OF THOSE STRATEGIES IS SELECTED.	*Main Activity Reporting Form*	Which risk factor did this activity address?	
23		Cancer Types	Drop Down Menu	<Select from drop menu> 1=Breast; 2=Cervical; 3=Colorectal; 4=Lung; 5=Prostate; 6=Skin; 7=Other; 99=DNK/Not stated. THIS FIELD IS COMPLETE FOR EACH STRATEGY UNDER GOAL 2 (PREVENTION AND EARLY DETECTION) AND WILL AUTOMATICALLY APPEAR WHEN ONE OF THOSE STRATEGIES IS SELECTED.	*Main Activity Reporting Form*	Which cancer did this activity address?	
24		Disparate Groups	Drop Down Menu	<Select from drop menu> 1=Geographic (rural); 2=Racial/ethnic; 3=Cultural/linguistic; 4=Uninsured/Underinsured; 5=Other; 99=DNK/Not stated. LINKED TO SPECIFIC SURVEILLANCE FOCUS STRATEGIES. OTHERWISE ENTER AS APPROPRIATE FOR OTHER STRATEGIES.	*Main Activity Reporting Form*	Which disparate population did this activity target?	
25		Activity Name	Text box	Unique name that identifies the activity from the Workgroups' and partner organization work plan.	*Main Activity Reporting Form*	What did the partner organizations commit to provide (i.e., resources) and do (activities) to bring about implementation of the respective strategy?	Do you want them linked? How?
26		Activity Description	Text box	Describe what you did and what happened (including facilitators or barriers encountered). ALLOW BOX TO EXPAND WITH TEXT ON THE FORM AND IN THE REPORT.	*Main Activity Reporting Form*		
27		Phase of Activity	Drop Down Menu	<Select from drop menu> 1=Building Relationships, 2=Identifying Resources, 3=Planning, 4=Implementing; 5=Evaluating, 4=DNK/Not applicable)	*Main Activity Reporting Form*		
28		Activity Status	Drop Down Menu	<Select from drop menu> 1=No action taken, 2=Activity initiated; 4=Activity ongoing; 4=Activity completed). IF AN ACTIVITY IS INITIATED IN A PREVIOUS REPORTING PERIOD BUT NOT COMPLETED.	*Main Activity Reporting Form*	What is the status of this activity since the last reporting period? PROMPT WHAT WAS THE LAST REPORTING PERIOD.	Is this level of detail desired? Is it feasible to collect it from the partner organizations? How?
29		Role of the Partner Organization	Drop Down Menu	<Select from drop menu> 1= Lead (Primary partner); 2= Co-Lead; 3=Secondary partner;	*Main Activity Reporting Form*	NEED TO DEFINE ROLES	Is there a need to differentiate? If so, operationally define terms.
30		Member Reporting the Activity	Drop Down Menu	List alphabetically by last name of the person reporting the activity.	*Main Activity Reporting Form*	SHOULD BE THE SAME LIST AS THE MEMBERS. COULD IT EVER BE ANYONE ELSE?	Could it be someone other than a member of the Board or Workgroup? Under what circumstances?
31		Objective of the Activity Met	Drop Down Menu	<Select from drop menu> 1=Yes; 2=No; 3=DNK/Unable to state In	*Main Activity Reporting Form*	Was the objective for this strategy (priority objective) met?	Should the focus be on the strategy or the priority objective? The relationship of objective to strategy is one to many. Possibly, it will take many activities to complete one strategy. What is useful? What is feasible?

Field #	Field Name	Database Label	Command Type	Command Detail	Name of the Database Form	Evaluation Detail	Questions for NHCCC
32		Most Significant Change	Text box	IMPACT OF THE COMPLETED ACTIVITY. What was a significant change that resulted from the activity? COMPLETE IF ACTIVITY STATUS =4.	*Main Activity Reporting Form*	In the leader's opinion, what significant change occurred as a result of meeting this objective?	Who would provide this information? Is it reasonable to expect that the Workgroup Chairs and/or Members could provide it?
33		Day		DD (01-31)	*Main Activity Reporting Form*	Day on which the activity was planned, implemented, or evaluated	
34		Date of Meeting	Date	Dates of regular Board, Workgroups, and Subcommittee meetings	*Meetings Reporting and Edit Form*	How will the Workgroups and Subcommittees provide this information to the Database Manager?	
35		Meeting Attendance	Radio Button	Select all members who attended the meeting on that date	*Meetings Reporting and Edit Form*		
36		Member Last Name	Text box	<Select from drop menu> Member's first name, middle name or initial, and last name. NEED CAPABILITY TO ADD NAME TO DROP DOWN LIST AS THEY ARE ADDED TO THE TABLE. NO NAME IS EVER DELETED FROM DATABASE.	*Member Reporting and Update Form*		
37		Member First Name	Text box		*Member Reporting and Update Form*		
38		Member Middle Initial	Text box		*Member Reporting and Update Form*	Who are the current members of the board? Who are the past members?	**NHDHHS wants the ability to print mailing labels.**
39		Member Degree 1			*Member Reporting and Update Form*		
40		Member Degree 2			*Member Reporting and Update Form*		
41		Member Degree 3			*Member Reporting and Update Form*		
41		Member Address	Text box		*Member Reporting and Update Form*		
43		Member Telephone	Text box	Enter numbers only. Automatically add the dividers. Require the area code.	*Member Reporting and Update Form*		
44		Member Fax	Text box	Enter numbers only. Automatically add the dividers. Require the area code.	*Member Reporting and Update Form*		
45		Member Email	Text box		*Member Reporting and Update Form*		
46		Date member joined or appointed:	Date	YYYY/mm/dd. Enter numbers only. Automatically add the dividers.	*Member Reporting and Update Form*	What date did the member join?	
47		Date member left	Date	YYYY/mm/dd. Enter numbers only. Automatically add the dividers.	*Member Reporting and Update Form*	When did they leave? Was someone else appointed?	
48		Member's Status	Drop Down Menu	<Select from drop menu> 1=Active (Not reported as having left the Workgroup or Board), 2=Inactive (Reported as having left the Workgroup or Board)	*Member Reporting and Update Form*	Status at the reporting period. Have not reported as having left the Workgroup or Board.	
49		Workgoup Name	Drop Down Menu	<Select from drop menu> 1=Primary Prevention; 2= Prevention and Early Detection; 3=Treatment and Survivorship; 4= Palliation; 5= Emerging Issues; 6=Not applicable/Not affiliated with a Workgroup	*Member Reporting and Update Form*	With which workgroup is the member affiliated?	Can they be on more than one? If so, how would that be handled?
50		Workgroup Member's Role	Drop Down Menu	<Select from drop menu> 1=Workgroup Chair; 2= Workgroup Co-Chair; 3=Workgroup member only; 4=Not applicable/Not affiliated with a Workgroup; 99=DNK/Not stated	*Member Reporting and Update Form*	What is the member's current role as of this reporting period? WHAT IF A PERSON HAS MORE THAN ONE ROLE?	Do you need this level of detail. Roles will change. Frequency of updates (i.e., reporting period).
51		Sub-Committee Name	Drop Down Menu	<Select from drop menu> 1=Prostate Subcommittee, DATABASE MANAGER CAN ADD IN OTHER UNITS AS THEY ARE DEVELOPED AND ADDED THEM TO THE DROP-DOWN LIST.	*Member Reporting and Update Form*	With which subcommittee of the workgroup is this member affiliated? NEED ABILITY (INSTRUCTIONS ON HOW) TO ADD AS THEY ARE DEVELOPED OR FORMED. NEVER DELETE ONE.	Relates to Partnership complexity. Do you need this level of detail? How would you use it?
52		Subcommittee Member's Role	Drop Down Menu	<Select from drop menu> 1=Subcommittee chair; 2=Subcommittee co-chair ; 3=Subcommittee member only; 4=Not applicable/Not affiliated with a Subcommittee; 99=DNK/Not stated.	*Member Reporting and Update Form*	What is the member's current role as of this reporting period? WHAT IF A PERSON HAS MORE THAN ONE ROLE? ALLOW UP TO 3 CHOICES: PRIMARY, SECONDARY, TERTIARY	Do you need this level of detail. Roles will change. Frequency of updates (i.e., reporting period).
53		NHCCC Board	Drop Down Menu	<Select from drop menu> 1=Yes, 2=No.	*Member Reporting and Update Form*	Is the member affiliated with the NHCCC Board?	
54		Board Member's Role	Drop Down Menu	<Select from drop menu> 1=Board Chair; 2=Board co-chair; 3=Board Member; 4=Not applicable/Not affiliated with a Subcommittee; 99=DNK/Not stated. COMPLETE IF NHCC BOARD EQUALS 1.	*Member Reporting and Update Form*	What is the member's current role as of this reporting period? WHAT IF A PERSON HAS MORE THAN ONE ROLE? ALLOW UP TO 3 CHOICES: PRIMARY, SECONDARY, TERTIARY	Do you need this level of detail? Roles will change. Frequency of updates (i.e., reporting period).

Field #	Field Name	Database Label	Command Type	Command Detail	Name of the Database Form	Evaluation Detail	Questions for NHCCC
55	Co_Belknap, Co_Carroll, Co_Cheshire, Co_Coos, Co_Grafton, Co_Hillsborough, Co_Merrimack, Co_Rockingham, Co_Stafford, Co_Sullivan, Reg_Dartmouth, Reg_Lakers, Reg_Monadnock, Reg_Seacoast, Reg_White Mountains		Radio Buttons	1=Belknap, 2=Carroll, 3=Cheshire, 4=Coos, 5=Grafton, 6=Hillsborough, 7=Merrimack, 8=Rockingham, 9=Stafford, 10=Sullivan, 11=Dartmouth/Lake Sunapee Region, 12=Lakes Region, 13=Monadnock Region, 14=Seacoast Region, 15=White Mountains Region. SELECT ALL THAT APPLY.	*Paid Media Reporting Form*		Would there be a focus at the community or neighborhood level? Do we need to include census tract? Would the partners even know if that level was targeted?
56	LengthDaysBB	Intensity Measure (2):	Open	Length of time ran (# of days)_ LINKED TO A SPECIFIC CHANNEL - SEE INTENSITY AND REACH MEASURES TABLE	*Paid Media Reporting Form*		
57	LengthSpotsCable	Intensity Measure (7):	Open	Length of spots (in seconds)___; LINKED TO A SPECIFIC CHANNEL - SEE INTENSITY AND REACH MEASURES TABLE	*Paid Media Reporting Form*		
58	LengthWeb	Intensity Measure (11):	Open	Length of time (# days) ad was on the Web site LINKED TO A SPECIFIC CHANNEL - SEE INTENSITY AND REACH MEASURES TABLE	*Paid Media Reporting Form*		
59	Media Channel	Media channel used:	Radio buttons	1=Billboard, 2=Magazine, 3=Mass mailings, 4=Multi-cable TV buy, 5=Newspaper, 6=PSA-educational, 7=Radio-AM, 8=Radio-FM, 9=Sign/poster, 10=Sticker, 11=TV, 12=Theater slide, 13=Transit bus, 14=Website	*Paid Media Reporting Form*		
60	Media Source	Source of media content:	Drop Down Menu	<Select from drop menu> LINK TO PARTNER ORGANIZATION TABLE FOR LIST.	*Paid Media Reporting Form*		
61	NumAdMag	Intensity Measure (3):	Open	Number of ads placed___; LINKED TO A SPECIFIC CHANNEL - SEE INTENSITY AND REACH MEASURES TABLE	*Paid Media Reporting Form*		
62	NumAdNew	Intensity Measure (8):	Open	Number distributed; LINKED TO A SPECIFIC CHANNEL - SEE INTENSITY AND REACH MEASURES TABLE	*Paid Media Reporting Form*		
63	NumBus LengthBus	Intensity Measure (10):	Open	Number of transit buses___; LINKED TO A SPECIFIC CHANNEL - SEE INTENSITY AND REACH MEASURES TABLE	*Paid Media Reporting Form*		
64	NumLocBB	Intensity Measure (1):	Drop Down Menu	1=Number of locations___; LINKED TO A SPECIFIC CHANNEL - SEE INTENSITY AND REACH MEASURES TABLE	*Paid Media Reporting Form*		
65	NumMail	Intensity Measure (5):	Open	Number of pieces mailed___, LINKED TO A SPECIFIC CHANNEL - SEE INTENSITY AND REACH MEASURES TABLE	*Paid Media Reporting Form*		
66	NumSpotsCable	Intensity Measure (6):	Open	Number of spots___; LINKED TO A SPECIFIC CHANNEL - SEE INTENSITY AND REACH MEASURES TABLE	*Paid Media Reporting Form*		
67	SizeAdMag	Intensity Measure (4):	Open	Size of ad (in square inches)_; LINKED TO A SPECIFIC CHANNEL - SEE INTENSITY AND REACH MEASURES TABLE	*Paid Media Reporting Form*		
68		Title of the Media:	Text box		*Paid Media Reporting Form*		
69		Intensity Measure (9):	Open	Number of days ran; LINKED TO A SPECIFIC CHANNEL - SEE INTENSITY AND REACH MEASURES TABLE	*Paid Media Reporting Form*		
70		Reach Measure (1)	Open	Circulation _____ LINKED TO A SPECIFIC CHANNEL - SEE INTENSITY AND REACH MEASURES TABLE	*Paid Media Reporting Form*		
71		Reach Measure (2)	Radio	Frequency: (Daily, weekly, monthly, other) LINKED TO A SPECIFIC CHANNEL - SEE INTENSITY AND REACH MEASURES TABLE	*Paid Media Reporting Form*		
72		Reach Measure (3)	Open	Gross Point Rating (AMA) LINKED TO A SPECIFIC CHANNEL - SEE INTENSITY AND REACH MEASURES TABLE	*Paid Media Reporting Form*		
73		Reach Measure (4)	Open	Impressions of number of people reached LINKED TO A SPECIFIC CHANNEL AND INTENSITY MEASURE - SEE TABLE	*Paid Media Reporting Form*		
74		Reach Measure (5)	Open	Number of screens on which movie theaters show the slides LINKED TO A SPECIFIC CHANNEL - SEE INTENSITY AND REACH MEASURES TABLE	*Paid Media Reporting Form*		
75		Toll-free telephone referral source used in the media campaign.	Drop Down Menu	<Select from drop menu> 1=Quitline, 2=ACS, 3=Other, 4=None	*Paid Media Reporting Form*		
76		Media Cost	Open	Amount from the paid media contract	*Paid Media Reporting Form*		Do we need to consider the possibility of earned or donated media? How would that be handled?

Field #	Field Name	Database Label	Command Type	Command Detail	Name of the Database Form	Evaluation Detail	Questions for NHCCC
77		Partner Organization Name	Drop Down Menu	<Select from drop menu> REFER TO TABLE FOR LIST.	*Partner Organnizations Update Form*		The Performance Measure Reporting Form WILL BE COMPLETED LESS FREQUENTLY -- MAYBE ANNUALLY?
78		Partner Organization Type	Drop Down Menu	the <Select from drop menu> 1=Advocacy, 2=Business/Industry, 3=College/university, 4=Government agency-federal, 5=Government agency-state, 6=Government agency-County/City, 7=Hospital/health system, 8=Medical Practice/Clinic, 9=Non-profit organization (Community-based), 10=Non-profit organization (National), 11=Other health care provider; 12==Professional organization, 13=Religious/Faith organization, 13=Other. PARTNER ALREADY LISTED IN THE DATABASE WILL HAVE THIS FIELD COMPLETED AND AUTOMATICALLY POPULATED.	*Partner Organnizations Update Form*	What organization does this member represent?	What is the level of participation by the organizational partner? The member may leave but not the organization. Someone could be appointed to represent the organization.
79		Performance Measures	Drop Down Menu	<Select from drop menu> REFER TO TABLE FOR LIST.	*Performance Measure Reporting Form*		THE Performance Measure Reporting Form WILL BE COMPLETED LESS FREQUENTLY -- MAYBE ANNUALLY?
80		CTA2010 Goal (Benchmark)		Call to Action 2010 Goal. LINK TO SPECIFIC PRIORITY OBJECTIVES. SEE TABLE. DO NOT CHANGE SO DO NOT NEED TO SELECT.	*Performance Measure Reporting Form*		The Performance Measure Reporting Form WILL BE COMPLETED LESS FREQUENTLY -- ON AN ANNUAL BASIS.
81		HP2010 Goal (Benchmark)		Healthy People 2010 Goal. LINK TO SPECIFIC PRIORITY OBJECTIVES AND STRATEGIES. SEE TABLE. DO NOT CHANGE SO DO NOT NEED TO SELECT.	*Performance Measure Reporting Form*		The Performance Measure Reporting Form WILL BE COMPLETED LESS FREQUENTLY -- MAYBE ANNUALLY?
82		Data Source 1	Drop Down Menu	<Select from drop menu> Numbered in alphabetical order. Refer to Data Sources spreadsheet. REFER TO TABLE FOR LIST. FOR MANY (IF NOT ALL) OF THE TOP PRIORITY STRATEGIES, A DATA SOURCE IS LINKED TO THE SPECIFIC STRATEGY.	*Performance Measure Reporting Form*	NEED CAPABILITY TO ADD AS OTHERS ARE IDENTIFIED.	The Performance Measure Reporting Form WILL BE COMPLETED LESS FREQUENTLY -- MAYBE ANNUALLY?
83		Data Source 2	Drop Down Menu	<Select from drop menu> Numbered in alphabetical order. Refer to Data Sources spreadsheet. REFER TO TABLE FOR LIST. FOR MANY (IF NOT ALL) OF THE TOP PRIORITY STRATEGIES, A DATA SOURCE IS LINKED TO THE SPECIFIC STRATEGY.	*Performance Measure Reporting Form*	NEED CAPABILITY TO ADD AS OTHERS ARE IDENTIFIED.	The Performance Measure Reporting Form WILL BE COMPLETED LESS FREQUENTLY -- MAYBE ANNUALLY?
84		Data Source 3	Drop Down Menu	<Select from drop menu> Numbered in alphabetical order. Refer to Data Sources spreadsheet. REFER TO TABLE FOR LIST. FOR MANY (IF NOT ALL) OF THE TOP PRIORITY STRATEGIES, A DATA SOURCE IS LINKED TO THE SPECIFIC STRATEGY.	*Performance Measure Reporting Form*	NEED CAPABILITY TO ADD AS OTHERS ARE IDENTIFIED.	The Performance Measure Reporting Form WILL BE COMPLETED LESS FREQUENTLY -- MAYBE ANNUALLY?
85		Type of provider education and support	Drop Down Menu	1=Forum, 2=Materials, 3=Newsletter, 4=Roundtable discussion, 5=Seminar, 6=Technical assistance, 7=Other	*Provider Education and Support Focus Activity Form*		
86		Setting for public education and awareness event	Drop Down Menu	<Select from drop menu> 1=Business, 2=Daycare, 3=Community, 4= College/University campus, 5=Hospital/Medical Center, 6=Local agency, 7=School, 8=Worksite, 9=Other	*Public Education and Awareness Focus Activity Form*		
87		Type of public education and awareness event	Drop Down Menu	<Select from drop menu> 1=Fair/festival, 2=Informal talk, 3=Mass Mailing, 4=Poster session, 5=Presentation, 6=Stomp/promotion, 7=Technical assistance/training, 8=Teleconference, 9=Website, 10=Workshop/Conference, 11=Other	*Public Education and Awareness Focus Activity Form*		
88		Number of people reached	Open		*Public Education and Awareness Focus Activity Form*		
89		Number of brochures/ pamphlets distributed	Open		*Public Education and Awareness Focus Activity Form*		
90		Source of the materials	Drop Down Menu	<Select from drop menu> REFER TO PARTNER ORGANIZATION TABLE FOR LIST.	*Public Education and Awareness Focus Activity Form*		
91		Type surveillance and monitoring	Drop Down Menu	1=BRFSS, 2=Develop new data collection system, 3=Medicaid data, 4=Medicare data, 5=New question added to BRFSS; 6=New Question added to YRBS. 8=Oversampling of disparate groups, 9=YRBS, 10=Other	*Surveillance and Monitoring Focus Activity Form*		

APPENDIX E:
SITT USER'S MANUAL TEMPLATE

User's Manual
Strategy Implementation Tracking Tool (SITT)

SITT - Developed by RTI International
June 2007

User's Manual
Strategy Implementation Tracking Tool (SITT)

Table of Contents

1.0 Introduction

1.1 Purpose of Manual

1.2 Organization of Manual

1.3 SITT Objectives

1.4 Conceptual Overview of the System Design

1.5 SITT Functions

Back-to-main-menu window
Radio buttons
Pull down menus
Text boxes

1.6 System Administrator

1.7 System Maintenance and Security

1.8 Technical Support

1.9 SITT Glossary of Terms

1.10 Navigating the Database

Welcome to SITT!

Figure 1.10 SITT Main Page

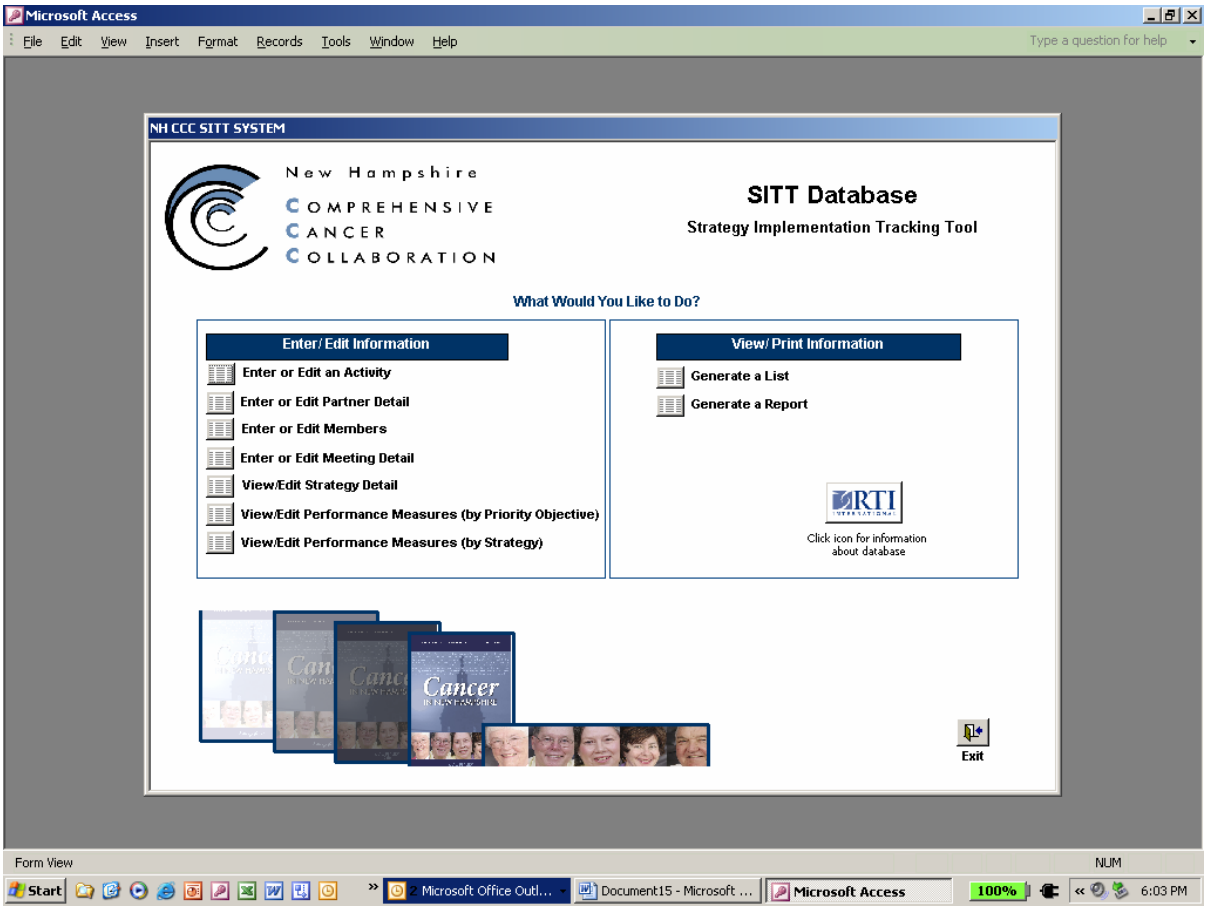


Table 1.10 Overview of Database Components

Database Form	# Forms	Purpose of Forms
Data Input		
Activity Reporting Screens	8	
Partner Organizations	1	
Members	1	
Meeting Detail	1	
Strategies	1	
Performance Measures (by Priority Objective	1	
Performance Measures (by Strategy)	1	
Data Output		
Lists		
Reports		

Instructions on Use: (What is it? What should the user do?)

2.0 Data Input

2.1 Activity Data Entry Forms

Figure 2.1.1 Activity Data Entry and Edit Screen

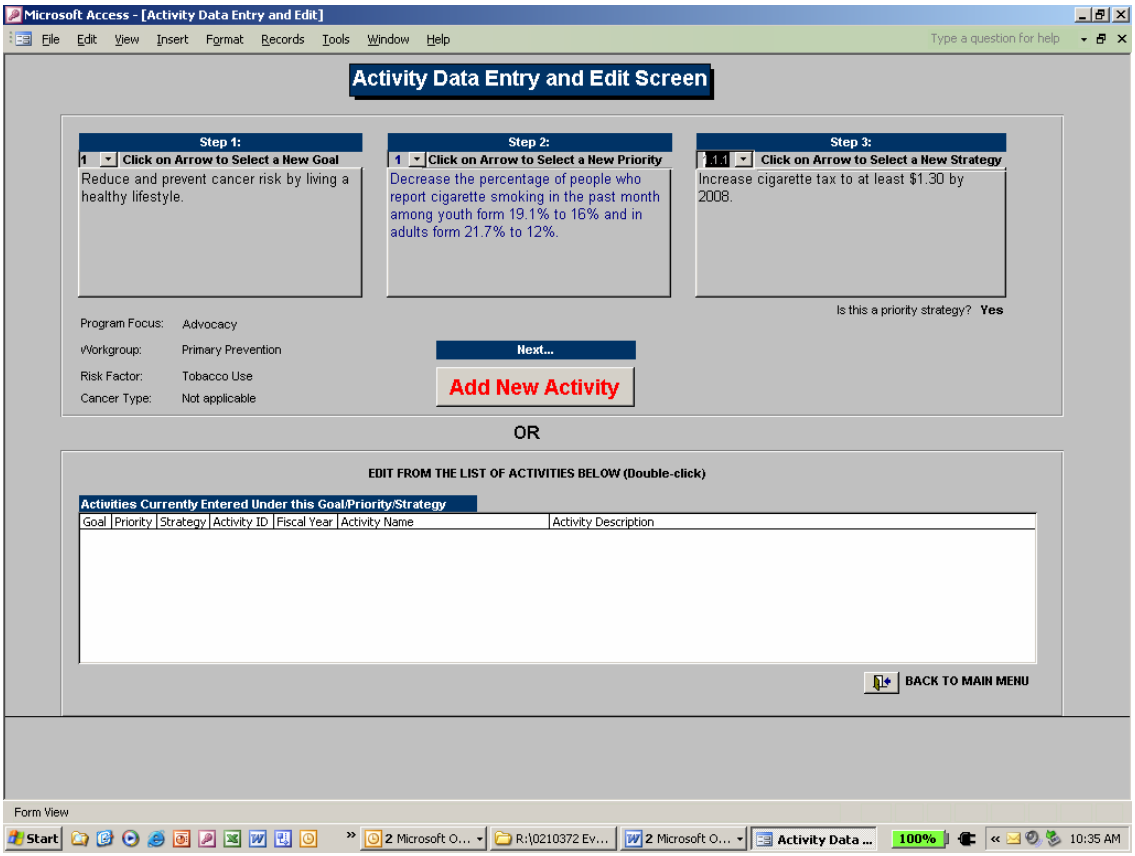


Table 2.1.1 Overview of the Activity Data Entry and Edit Screen

Field Names	Instruction for Completing the Fields
Goal	
Priority Need	
Strategy	
Priority Strategy	
Program Focus	
Cancer Type	

How to Edit Activities in the Database: